Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G910, 12/10/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JIMMIE WADE 0.500 PM 06 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKING BAYVIEW MEDICAL CENER BALTIMORE BAUTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1959 1 XM 2 - F Months Days Min (Month, Day, Year) Hours 282-60-2717 Director 51 Virginia Usual Residence of Decedent items 23a or 28a-f show her must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Sparrows Point 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7613 North Point Road 21219 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 years Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Jimmie Ray Wade Sr. Jimmy Joyce Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Whiteford Step-father 7613 North Point Road, Sparrows Point, MD. 21219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 8, 2010 Baltimore, MAryland Sign, ture of Funeral Service Lio-see Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Part 1. Enter the dispase, or complications that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate Interval Between Immediate Cause (Final IVER Çnysician/ Onset and Death disease or condition Medical resulting in death) xaminer CARCINOMA ATOCELLUL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) gned by the attending physician and be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No a 🗆 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ₩ Natural (Month, Day, Year) 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 DEC 06,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD MWAKINGWE 4940 EASTERN AVE 31. Date filed (Month, Day, Year) **NFC** 0 8 2010 State 32. Registrar's Sig Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland Department of Health and Mental Hygiene Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) ILSON Month V Physician/ JAN 111 Medical 4b. City Town, or Location of Death 4c. County of Deat 4a. Facility Name (if not institution, give street and number) Examiner 9LTIMORE OSP NI If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Day, Days Hours Min Country) 1 XM 2 □ F VA 30.40.1 3 Lyrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 10b. County 10a. State within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 13altimone 1 X Yes 2 ☐ No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò IJSA Funeral "natural", or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 131ack 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore Packer cad grade Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surelame) Hizabeth McDanie မ Louise W. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or Attack trenue Baltimore MD Wife. Wilson Milared 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Woodlawn, MD 202 2010 Woodlawn Cemeten 4 ☐ Donation 5 ☐ Other (Specify) Vaugno C. Greene Funeral Services 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Read Randallotown MD 21133 iberti 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse and Death LNTR Immediate Cause (al Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying MEDICAL EXAMINER Due to (or as a consequence of) Examin CERTIFICATION APPROVED BY Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed and -tran Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed page 2 should peen s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed' 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate Proprieted filled in by the funeral director, page ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be niner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 X Yes 2 200 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 29b. Signature and title of certifier 2010 30. Name and address obserson who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-f per me,g910,12/08/2010dhb

State of Maryland / Department of Health and Mental Hygiene
Reg. No.
Reg. No. 1 - For State Registrar Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year Physician/ Joseph L. Wilson 11 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center <u>Annapolis</u> ArundelCo 9. Birthplace (State or Foreign Country) GA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral Days Hours 1 ፟ M 2 □ F 09/22/ 1937 73 Director 257-58-1714 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Warfield Rd. 21060 .S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes : 2 X No Maryland 21215-0036 1 Yes 2X No Specify Specify: 3 🗆 Widowed 4 🗆 Divorced Black Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 8th Grade Maintenance Glen Ridge/Apt Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Arthur Wilson <u>Laura Jones</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Minnie Brown(sister) Deacon Hill Ct., Baltimore, MD 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
OSEDA TREMATORY 11/04/10 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD ²² Name and Address of Facility Own Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21. Signature of Funeral Service Licenses PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final Physician/ S.e disease or condition resulting in death) PSIS Medical Due to (or s a consequence of): Examiner oday s neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and tracture UKKHOWIN signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 24€ No Yes 2 XNo 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner?

X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at work?

Of a car collided with a car. Hospital: 2 €N0 Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 7:15 Natural 5 Pending 03/11/2010 2 X Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) GOVETNOT, RICCITE Highway North at warrield Road Glen Burnie, MD 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MN 69566 11/2/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis MD 21401 1005 Medice YOU'K WAY Ivelisse 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ December WILSON WILLIAM Medical 4a. Facility Name (if not institution, give street and number, or Location of Death 4c. County of Death Examiner meriand N/A General Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, ge (In vrs. last birthday If Under 24 Hrs. **Funeral** Months 1 🗆 🙀 2 🗆 F Hours Maryland Director 76 Apr 27, 1934 <u>214-32-1339</u> Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hipry or or her traumatic event, the Medical Examiner must be notified at any hipury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐¥es 2 ☐ No **Baltimore** Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 21207 2679 West Park Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ 1**X**0 Specify. Yes, Give Specify: Black 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Construction Company Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lottie Wilson Douglass Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2679 West Park Drive Baltimore, Maryland 21207 Raymond Wilson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State any injury o Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) Western Star Cemeterly 22. Name and Address of Facility 21. Signature of Funeral Servici Licensee Estep Brothers Funeral Service, P. A 1200 Futery Place Politimore, Md the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin Approximate Interval Between
Onset and Death

MKNOUNT Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transi Cause (Disease or impury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by umonare bstructive 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available this certificate has braid rail director, page 2 s prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: in 24 hours after death.

he Funeral Director; After in pleted filled in by the funeral Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29d. Date signed (Month, Day, Year) 12/02/2010

State

Registrar

naryland

ne and address of person who completed cause of death (Item 23a) (Type, Print)

mil)

32. Registrar's Signature

Swereko

8 2010

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19,2010 Physician/ Month Susan Lynn Arthurs November 1:15 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9228 Gue Road Montgomery Damascus 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 3, 1966 9. Birthplace (State or Foreign Country) New Jersey **Funeral** Min. 1 M 2 XF Months Days Hours 43 Director Yrs 142-74-2815 Usual Residence of Deceder 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9228 Gue Road 20872 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ò 1 Never Married 2 X Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Judith Altland Applegate Dennis Bortner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith E. Arthurs - Husband 9228 Gue Road, Damascus, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 **X** Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Souls Cemetery Nov.22,2010 Germantown, Maryland 21. Signature of Mneral Service Lice 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 6401 Ridge Road, Damascus, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ (MNCFIN HODEL METASTATIC disease or condition MONTH Medical resulting in death) Due to (or as a consequence of) Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year isigned by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown s been si should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has autopsy performed? death? After this certificate ☐ Yes 2 👿 No I ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 🗓 No ျဉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🗓 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗀 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 after deat Director: within 24 hours a

Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28768 MD November 19, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BACTILORE

State Registrar

filled in by

4 Homicide

31. Date filed (Month, Day, Year)

NOV

determined

32. Regist ar's Signature

MANTO P-EISENBENGER - JOHNS HOPKINS HOSPITAL 1650 DECEMNSST IMS!

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38506 Certificate of Death

	Physicia Medic Examin	n/ :al er	1. D 4a. F
	Funeral Director		5. So 2. Usu 10a
Aaryland 21215-0036	should be filed within 72 hours after death with the Maryland n and Mental Hygiene. I show some says or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	Usu 10a. Mai 10e. 11. I 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1

Baltimore, M

Registrar

Division of Vital Records, P.O. Box 68760

	1	_ State	state of Maryland		tificate of D			Reg. No.	2010	38506
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ith		3. Time of Death
Physiciar Medic	al .	Evelyn Mae	Anderson				Novembe			1:40 A M
Examine	er	4a. Facility Name (if not institution, give stree			4b. City, Town, or Boonsbo		1		County of Death Washing	
Funeral		230 Potomac Street 5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign
Director		230-23-6329	12 X F 44	Yrs.	Months Days	Hours Min.	May 4,	196	6 Vir	ginia
or at	'n	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	eation					10d. Inside City Limits
larylar 3a-f sh ified a	ecto	Maryland Washington	n B	oonsbo	ro					1 ឺ Yes 2 □ No
the N		10e. Street and Number			10f. Zip Code				izen of What Cou	untry?
h with ns 23; must i	Funeral Director	230 Potomac Street		140.11	21713		anifu Van ar Na		S.A.	is an Indian
r deat or iten iiner r	by Fu	11. Marital Status1 ☐ Never Married2 ☐ Married12.	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No		Vas Decedent of His Yes, specify Cubar		o Rican, etc.)		 Race - Amer Black, White 	
rs afte iral", d Exan	ed b	3 Widowed 4 Divorced	If Yes, Give Year or Dates	1	Yes 2 X No	Specify:			^{Specify:} Whi	te
2 hour	Completed	15. Decedent's Educa (Specify only highest grade of		(Give I	lent's Usual Occupa kind of work done di	ition uring most of wor	king	16b. Ki	ind of Business I	ndustry
ithin 7 ene. • than he Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)	ĺ	ONOT use retired)			Med	lical	
iled w	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden S	Surname)	
d be f Menta arked atic e	၉	William Macon Ande	rson				Rhodes			
shou h and 7 is m raum		19a. Informant's Name/Relationship (Type,		1	ng Address (Street a					
and 2 Healtl tem 2 ther 1		William M. Anderson 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of		Date		ocation - City or	
age 1 ent of nt; If i		1 X Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	HOVAL HOLLI State	-	natory`or other place hurch Cem		2/2010	Pri	nce Wil	liam, VA
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importment of Heath and Mental Hygiene. Importantial filem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens te	00	22	. Name and Addres	s of Facility Ba	st-Stau:	ffer	Funeral	Home, PA
8855		* Canlar	Level		606 Old N				oro, MD	21713
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mysician/ Medical		disease or condition resulting in death)	Due to (or as a consequ	nc U	in known	poine	2			to month
Examiner			Dao to for as a someoge			AW -				
_ +	Examiner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience ofj.					<i>)</i> .	
and and-transi	xan	Cause (Disease or iinjury that initiated events c. resulting in death) Last	Due to (or as a consequ	uence of):					-	
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	Medical	- u.								
ath certifica attending p I for use as t	lan/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregna 1 🔲 Live Birth 2 🔲 Feta	aldeath 3		:y		- 1	23d. Date of de Month	livery Day Year
e deat the at hed fo	Physician/N	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of of 9 ☐ Unknown	death 5 L	Other (specify)					
es that the des signed by the s I be detached f	by Ph	Part II. Other significant conditions contr	buting to death but not res	ulting in the u	underlying cause giv	ven in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
uires 1 in sign	ed b						1 🗆	Yes 2	₽No 3□P	robably 4 Unknown
aw require as been si 2 should	Completed						24a. Was	psy	prior to	topsy findings available completion of cause of
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sician: The law certificate has l irector, page 2 s	Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	ED/Outratia	Oth	er:	Home 5 Res	idanaa 6	Other (Spec	sifu)
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To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending to the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a		29a. Certifier 1 Certifying Physici	an: To the best of my know	ledge, death	occured at the time	, date and place,	and due to the c	ause(s) ai	nd manner as st	ated.
n 24 h	Medical	(Cheek 0 Medical Evamina)	On the basis of examination of the basis of mactioner. To the best of m	n and/or inves	stigation, in my opinio	on, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner stated.
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu		29b. Signature and title of certifier	1 1	2.1	29c. License	e number		29d. Da	ate signed (Mont	h, Day, Year)
1		Muchal "M	reland .	MU		4166	/		11.29	, / 0
H-5		30. Name and address of person who com	1- 11	n 23a) (Type,	Print) Medical	lam	us the	2 5/0	, town	MO
		Michael Mil	inact VI	10 1	-501100	(- ()-()				

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vvaller Noble Affai	1- For State Registrar	State of Maryla	•	nent of Hear cate of Deat		lental Hyg	iene Reg.		3850
Physician		, Middle,Last)					Date of Death		3. Time of Death
Medical Examine	waiter	r Noble Arran		I a a a			Month December 2		1400 hrs
	120 Arrants Road	nstitution, give street and nu d	mber)	4b. City, 1 North	own, or Locat	ion of Death		4c. County of De Cecil	eath
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Director	212-52-6549		51	Yrs. Month		ours Min.	02/19/	1959 For	eign Elkton CMarryland
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any .	10a. State 10b. Co	ounty	10c. City, Tow	n or Location					10d. Inside City Limits
1426 That the Maryland or 28a-f show fied at once.	Maryland C	Cecil	N	orth East					1 Yes 2 No
the Maryland as or 28a-f she diffed at once	10e. Street and Number	D 1		10f. Zip			_	Citizen of What C	
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r death with or items 23 must be no	11. Marital Status 1 Never Married 2			 Was Decede If Yes, specif 		Origin? (Speci ican, Puerto Ric		14. Race - An White, etc	nerican Indian, Black,
ter de		1 Yes Divorced If Yes, Give Year	2XX No	1 Yes 2	vztzNo soe	cify:		Specify: W	hite
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5-0036 led within 72 hour tygiene. other than "natu the Medical Exar Completed	12			Truck	Drive:			Truckin	g
Baltimore, MD 21215-0036 Bernit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumantic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	17. Father's Name (First, M Walter N. A	Middle, Last) Arrants, Jr.	-		18.Mo	ther's Name (Fi Nancy		den Surname)	
213 ould b d Men s mark		lationship (Type, Print)	19	9b. Mailing Address	(Street and	Number or Rura	Route Numbe	r, City or Town, St	ate, Zip Code)
MD d 2 sho lith and n 27 is numati	Arlene Arran			120 Arran					
s an of Hea	20a. Method of Disposition	n emation 3 Removal fro	m State crema	of Disposition (Name story or other place)		Dece		Oc. Location - City	or Town, State
Page nent or oth	4 Donation 5 Ott	her Specify:	Metho	dist Ceme	ted tery	6, 2		North Ea	st, Maryland
Baltimore, permit. Pages 1 an Department of Hec important: If ite	21. Signature of June 191	ervice Licensee	·	22. Name and	Address of Fa			ral Home	
	Record Francisco	ase, or complications that ca		127 Sou	th Main	n Stree	t, Nort	h East,	Maryland2190
Physician /Medical	failure. List only one	cause on each line.							Approximate Interval Between Onset and
Examiner	Immediate Cause (Final dis or condition resulting in de		ensive Atl	neroscler	otic Ca	ardiova	scular	Disease	Death
	Sequentially list conditions								
it xaminer	if any, leading to immediate cause. Enter Underlying C	Cause	consequence of):						
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b. Box 68760, the death certificate be execute by the attending physician and ched for use as the burial - tran Physician/Medical E	IF FEMALE: 23b. Was decedent pregnar		outcome of pregnancy rth	2 Fetal death	3 Fet	opic pregnancy		23d. Date of deliv Month	ery Day Year
th cert	past 12 months?	4 Pregna		5 Other (Spec		-pro programoy	3	Mona	Day Teal
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Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate by a firer death. *I Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be deached for use as the bur artification: To Be Completed by Physician/Mec		conditions contributing to	death but not resulting	ig in the underlying	cause given ir	n Part I.	23e. Did tobac		to the cause of death?
duires en sig uld be							24a. Was an		
Sorce law re has be 2 sho							autopsy performe	prior t	autopsy findings available completion of cause of
Records, The law require, ficate has been sign, page 2 should be Completed		-12-11-					1 ✔ Yes 2	No 1 ✓	
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nding th. :: Aft	1 X Natural 5	(Month,	Day,Year)	Time of Injury	1 Yes 2	_ 1	i. Describe now	injuly occurred	
isic Atter er deal by th	2 Accident	Investigation 28e Place	of Injury - At home, f	arm, street factory			Location (Stre	et and Number or	Rural Route Number, City
Division o oppital or Attending hours after death. neral Director: After filled in by the fune Certification:	3 Suicide 6 4 Homicide	Could not be determined (Specify)		, 5501, 1401019,	Daliding	201	or Town, State		and route number, City
		ring Physician: To the best	of my knowledge, de	ath occurred at the	time, date and	I place, and due	to the cause(s) and manner as st	ated.
To the He within 24 To the Pound to the Pound to complete!	one) 2 Medica	al Examiner: On the basis of and manner sta	f examination and/or i						
F 3 F 8 S	29b Signature and title of o		1	29c.	License numb	per	29	d. Date signed (A	fonth, Day, Year)

State Registrar

DHMH 17 Rev 1/2001 OCME 2006 Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D.

31. Date filed (Month, Day, Year)

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

December 3, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me,g910,12/08/2010dhb Certificate of Death For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2010 John Aubrey Barbour 1346 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death E1kton Ceci1 Union Hospital Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 0011120, 1963 1 🗶 M 2 🗆 F Months Days Hours Min. Maryland 47 Director 216-88-2204 Usual Residence of Decedent or 28a-f show e notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked cher than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No E1kton Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 210 North Street, Apartment 3 21921 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) 12 life. DO NOT use retired) College (1-4 or 5+) Automobile Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Aubrey Burton Barbour Mary Phyllis McKeever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie H. Barbour/Wife 210 North Street, Apt. 3, Elkton, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) 11, 2010 West Chester, PA Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ tote MORIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 30 60NS sever 940KCC quantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 2 No 1 Yes 2 g 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s performed 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner?

1 X Yes 2 1 Be 26. Place of Death (Check only one) Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury **Fou**(**M**(**1**) *tb. Day, Year)* **11/03/2010** 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Found: 7:00a. Natural 5 Pending work?
1 Yes 2 No Unknown 2 Accident Investigation 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) Found: 210 North Street, Apt. 3, Elkton, MD 4 Homicide determined Found: Home 1 Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 0055/90 a1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Baust Elkton Vying real MO

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Sigulature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) 2010 Physician/ 9:20P Burch November Μ. Anna Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth March 5 **Funeral** Hours 1 M 2 X 89 Months 1921 Pennsylvania 168-14-6384 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director 1 Yes 2 No Brookeville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20833 United States Funeral 22006 New Hampshire Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: White Specify: 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) U. S. Government Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ပ Margaret Krause Alfred Scripp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22006 New Hampshire Ave., Brookeville, Md. 20833 David C. Burch / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/22/10 Silver Spring, Md. Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee Xoy Box 5038, Laytonsville, Md. P. O. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Alzheimer's Disease Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the Enter Inderlying Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy 3 Day Year in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown TIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an HTN autopsy performed? death? 2 🔼 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 🖼 No 4 Nursing Home 5 Residence 6 X Other (Specify) ည 24 hours after death. Funeral Director: After this 28b. Time of 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: injury 1 🗹 Natural 5 Pending 1 Tyes 2 No Investigation Accident filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi (Check the only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat@e and title of certifie 10 8 R 143201

State Registrar

DHMH 17 Rev 7/2009

6001 Muncaster Mill Road, Rockville, Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

ar's Signature

Debrah Miller, CRNP

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#5,17,18per FHState of Maryland / Department of Health and Mental Hygiene State Registrar 11/16/2010 AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death 9,2010 Year Physician/ November 1315 Barbara L. Broadnax Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 5983 Tyler Road Deale If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 230cia 8ecy 10 Number 228-44-5997 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Virginia 0672071935 1 □ M 2 😾 F 75 Director Usual Residence of Decedent 10d, Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County within 72 hours after death with the Maryland Director 1 Yes 2 X No Deale MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20751 USA 5983 Tyler Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Year or Dates Specify: White id Mental Hygiene. marked other than "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 1 and 2 should be filed with Health and Mental Hygid Item 27 is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) -UNK Eva Elizabeth Toliver ပ Luther Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 701 Tyler Point Road Deale, MD 20751 Joy Shay Friend or other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Page 1 a
Department of H
Important; If ite
any injury or ot cemetery, crematory or other place, Atlantic Crematory Page 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/2010 Glen Burnie, MD 21. Signature of Funeral Strvice Licensee 12 Ridgely Ave Annapolis,MD 21401 22. Name and Address of Facility Hardesty Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ponset and Death Immediate Cause (Final disease or condition Acute Bron Physician Medical resulting in death) Due to (or as a consequence of DARCO Examiner Obstruct Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ed by the a detached f g Unknown g 🗌 Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed b þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 s autopsy performed? death? 2 🗆 No 1 Yes this certificate 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔄 No 1 Inpatient 2 ER/Outpatient 3 DOA ျပ 28b. Time of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) cal 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medic 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certification 20c License number è 10,2010

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 1 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Ramona 3:31 Shalequa Brown AM November 14 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Itospital Harbor Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 20 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country)

W York Months Days Hours 1 □ M 2 7 F 059-62-7768 33 1977 New Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County iral", or items 23a or 28a-f show Examiner nated be notified at 1 □Yes 2√ No Director Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4205 Pascal Ave 21226 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: <u>≥</u> Specify: 3 Widowed 4 Divorced **Black** "natural" Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, Its Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Testing Analyst RWD Technologies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Charles D. Brown Debbie Gadson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a other t Wayne A. Brown II(Husband) 4205 Pascal Baltimore, Md. Ave 21226 20a, Method of Disposition 20c. Location - City or Town, State 20b. Receding position (Name of cemetery-crematory or other place) Date Department of Important: If it any Injury or o 1

Burial 2 □ Cremation 3 □ Removal from State Memorial Park 11-18-10 Annapolis, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Winname Reverse of & cilisons Mortuary, P.A. 821 West St. Annapolis, Md. 12, Been 110048 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial hou disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any leading Limit data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending howeviren and certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🔽 2 N 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠res 2∐No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

South

VI 6 2010

1001

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edna R. Hill, mo

over

041699

, Baltimore, marylan

November

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No/ 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Rita B. Brandon Physician/ 1:10 A November 2010 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Arnold FutureCare Chesapeake 8. Date of Birth (Month, Day, Jan 11 g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Country) Maryland Days Hours 1 🗆 M 2 💢 F 85 218-12-6518 .1925 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland Director Severna Park Anne Arundel MD 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 21146 831 Ritchie Highway Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S 1. Marital Status Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give 3 😾 Widowed 4 🗆 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Realtor 12 Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) and Mental H permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item Z7 is marked o any injuy or other traumatic eve once. 2 Sophia Blair George N. Zellinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21304 Zion Road Brookeville, MD 20833 / Nephew Walter A. Romans, Jr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 20c. Location - City or Town, State 20a. Method of Disposition November 22 1 XBurial 2 Cremation 3 Removal from State Baltimore, MD 4 Donation 5 Other (Specify) 2010 Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine pate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to r as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical funeral director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directions. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nursa Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only une 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifig D53111 16 2010 MP of person who completed cause of death (Item 23a) (Type, Print) Hung T. 30. Name and addres ANNAPOLIS TIDE WATEN COLONV 1-A 200 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7010 lovember Robert Clyde BARNHART, Sr Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 1 🕅 M 2 🗆 F Days Hours Min. 920 Pennsylvania Yrs. **Director** 90 Sept. 213-18-8529 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No Maryland Washington Hagerstown 10g. Citizen of What Country? Funeral 130 E. Irvin Avenue 21742 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates. 1943-45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the Conductor Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clyde L. Barnhart Nora Hope 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra 13320 Hickory Hill Road, Hagerstown, Md. 21742 Robert Barnhart, Jr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 11/27/10 Hagerstown, Maryland Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Mayrland 211740 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Monto Myelody 18 Medical Due to (or as | consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last death certificate be executed Due to (or as a consequence of): physician a s the burial-1 Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown P.0. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director, After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1년 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-5+ Hajeropun MO Cames 11110

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 25,2010 Physician/ November 8:28 Christina Holly Bradshaw Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Washington Williamsport 7700 River Rock Ct. 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthdav) 5. Social Security Number Funeral (Month, Day, Year) June 2, 1986 Tennessee 1 M 2 K Days Hours Min 24 415-49-7729 June Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1 Tes 2 X No Maryland Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō or than "natural", or items 23a on the Medical Examiner must be i Funeral USA 21795 7700River Rock Ct. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married by 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 within 72 hours after Specify: White 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Salon Beautician 12 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H is marked of Department of Health and Menta Important: If item 27 is marked, any injury or other transminus. မ Katherine Lynn Kline James Leslie Bradshaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7700 River Rock Ct. Williamsport, Maryland 21795 (Fiance') Nick Ceffalia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Hagerstown Crematory | Nov.26,2010 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Osborne Funeral Home P.A. n aneral 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic months Priysician/ sarcoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: certificate has been signed by the attendin rector, page 2 should be detached for use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes neuroplastoma 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Yes 2 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 26. Place of Death (Check only one) 25 Was case referred to medica Be examiner? Other: 4 Nursing Home 5 MResidence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No iniury 5 Pending 1 Natural Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 26,2010 Cynthea Kuther-Sands, mo D4745 Cynthia Kutther Sands NO Hospice of Washington County 747 Northern Avenue 31. Date filed (Month, Day, Year) 32. State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 16, 2010 Sr. Physician/ Richard Berry 3:25 Charles рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico Salisbury 709 Schumaker Lane 9. Birthplace (State or Foreign Country) Delaware If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Months Days Hours Min (Month, Day, Year) 96 221-05-1281 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10a. State Director 1 ☐ Yes 2X No Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21804 Funeral 709 Schumaker Lane death with Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Navy Black, White, etc. 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Divorced 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Ms College (1-4 or 5+) Elementary/Seconday (0-12) Board of Education teacher/administrator 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marietta Neeld John Stewart Berry Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 709 Schumaker Lane, Salisbury, MD 21804 Ethel B. Berry/spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial 11/22/2010 Salisbury, MD 4 Donation 5 Other (Specify) Park 21. Signature of Funeral Servi, e Censee 22 Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kest K (5) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ HEART FAILURE CHAGESTIVE MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** YEAR > CHROLOMYOP Sequentially list conditions, if any. leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown RENAL STAGE 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 200 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 1 Tyes 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Medical Certificate: 27. Manner of Death 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 6mit 2010 036576

State

Registrar

1665 WOODBROOK DR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

3

31. Date filed (Month, Day, Year)

NOV 2

TRAVITE

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ NOVEMBER 2010 13 2:55A LARRY EUGENE BICKEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, If Under 6. Sex 1 A M 2 ☐ F **Funeral** 191-40-2223 Days Hours Min. July 15 Day 1948 Tilinois 62 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 Yes 2X No Fairfax Burke VA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 22015 6116 Wicklow Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 29 yrs "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) USAF Officer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Mabel Hartzell Paul E. Bickel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22015 6116 Wicklow Dr. Burke, VA Christine P. Bickel/Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 XCremation 3 ☐ Removal from State 11/23/10 Chantilly, VA 4 Donation 5 Other (Specify) Cremation Center 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Murphy FH 4510 Wilson Blvd. Arl., VA 22203 ulke 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): Davis disease or condition Medical resulting in death) **Examiner** Vez Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last -tran and Due to (or as a consequence of): the burial attending physiclan Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death signed by the a signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed' 1 ☐ Yes 2 🗷 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 2 🔀 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: After injury 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Suicide Investigation within 24 hours after death

To the Funeral Director; /
completed filled in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DG4507 November, 19,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CR 20 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 NICOLE

State Registrar

DHMH 17 Rev 7/2009

Date filed (Month, Day, Year)

NOV 2 3 2010

alla

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Simone Contee Vovember 2011 10:26 am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Lanham Doctors Community Hospital 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Min. Hours 1 M 2 X F O(C) 244 Year 981 Maryland 29 **Director** 213-98-2032 Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MarylandPrince George's Landover 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 USA 3109 75th Avenue Apt 303 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1X Never Married 2 Married þ 1 ☐ Yes 2 X No 3altimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2X No Specify. "natural", 3 Widowed 4 Divorced Specify: **Black** Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Ō FedEx Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mazie Simms Marvin Contee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mazie Contee (Mother) 3109 75th Avenue Apt 303 Landover, Md.20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) LOV Moses 11-13-10 Lothian, Md. Mame Research Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. B00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Metastatic cervical Physician disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death Day Year 4 Pregnant
9 Unknown g Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.
To the Funeral Director: After this certificate has to completed filled in by the funeral director, page 2 so autopsy performed 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မြ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parker

Daniel Alexander 12700 Goodloes Promise Dr.

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

052815

29d. Date signed (Month, Day, Year)

Md.

2010

20720

6

Bowie,

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for AMFND#18 per FH State of Maryland

1 = State 11/16/2010 AACO HEALIH DEPT. CMH Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Manth / 12 Day 2010 2010 10:18 A M Physician/ Kimberly Robin Cole Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) MD Hours 09/12/67/1964 1 M 2 X F 46 Director 213-86-5125 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County 10a. State death with the Maryland Director 1 Yes 2 No "natural", or items 23a or 28a-f s dical Examiner must be notified MD Anne Arundel Edgewater 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21037 1701 Ridgely Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2XXNo Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2XXXNo Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office admin Insurance 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental I is marked or ပ Connie Lweis Lewis Donald R. Cole 1 and 2 should b of Health and Mei item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 812 Birch Trail Crownsville, MD 21032 Ashley Raymond (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of Important: If it any injury or o Page 1 ō 1 Burial 2 XXremation 3 Removal from State 11/15/2010 Glen Burnie, MD Atlantic Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home 21. Signature of Funeral Service Co 10 MD 21401 Annapolis, Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a con Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregpant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No 1 ☐ Yes ∠ ⊑ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 No 25. Was case eferred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: work 1 Natural 5 Pending 24 hours after death.

e Funeral Director: Afte 1 Yes 2 No Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be within 24 hours after de
To the Funeral Directo
completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29d. Date signed (Month, Day, Year) 29b. Signature a 20 pleted cause of death (Item 23a) (Type, Print) 30. Name and eddress of person W N 31. Date filed (Monti istrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Maryland / De	epartmen Pertificate				Reg. No.	0 3851	9
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4	Examin	er	4a. Facility Name (If not institution		-			Location of De	eath	4c. County Anne	Arundel	
	Funeral		Fairfield Nu 5. Social Security Number		Age (In yrs. last birtho		1 Year	If Under 24 h	Irs. 8. Date of Bir (Month, Da	th	Birthptace (State or Country)	Foreign
	Funeral Director		215-30-8596	1□M 2∏F	76 Yrs	Months	Days	Hours M	Iin. (Month, Da Auq. 2	y, Year) 7.1934	Maryland	
	D.		Usual Residence of Decedent					-			1.0.1.1.0.	
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	Ne M	Director	MD Anne	Arunder	rasaue		0-1-			10g. Citizen of V		-X
	with a or	ä	311 Delma	Δνερμε		10f. Zip	21122			USA		
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21215-0036	within 72 hours after death with the Maryland ane. then "natural, or lieme 23a or 28e-f show the Medical Examinar must be notilled at	Completed by	15. Decede (Specify only high	nt's Education est grade completed)	(0	ecedent's Usua Give kind of wo fe. DO NOT u	rk done c	during most of	working	16b. Kind of B	usiness/Industry	
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	Hygin other ent, t	a	17. Father's Name (First, Middle	e, Last)		HOMER	DICE.	18. Mother's	Name (First, Middle			
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Maryland	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Ma		19a. Informant's Name/Relation	nship (Type, Print)		3		and Number of	Rural Route Numb	er, City or Town,	State, Zip Code)	
_	of Health of Health litem 27 I		Debbie L. Fre	eland / Dau				ow Cour	t Pasade			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Department of Health and Mental Hygiens than "natural", or Itema 23a or 28e-f show important: If item 27 is marked other than "natural", or Itema 23a or 28e-f show any hours or other traumatic event, the Medical Examinat must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation	n 3 □Removal from Sta	20b. Place of D Glen Ho	isposition (Nar crematory or d NON MO	me of other place	al Nov	zember 20		City or Town, State	
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Ba	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Signature of Funeral Service	e Licensee		Barran 495 Ri			P.A. Seve Seve	erna Par erna Par	k Funeral H k, MD 21146	iome
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39)	death certifica e attending pt id for use as t	Physician/Med	IF FEMALE:									
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DHMH 17 Rev 1/2001

10-08893 Keith Conway Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2010 38520 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day November 20, 2010 0539 hrs Medical Examiner Keith Conway 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Glen Burnie Anne Arundel **Baltimore Washington Medical Center** 5. Social Security Number If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Months Days Director Hours Many land 219-82-1295 1X M 2 F 49 Dec 29 1960 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c, City, Town or Location Maryland Anne Arundel 1 Yes 2 X No Odenton or 28a-f show Examiner must be notified at once. 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 673 Old Waugh Chapel Rd. 21113 Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married Yes If Yes, Give Year or Dates: Yes 2 No specify: hours after 3 Widowed 4 Divorced Specify: Black ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be filed within 72 I rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "", or other traumatic event, the Medical E. 21215-0036 12th None None 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Sylvenia V. Williams Aaron Conway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21113 Sheila Isler(Sister) 673 Old Waugh Chapel Rd. Odenton, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State rfant: 1 St. Rest Cemetery 11-27-10 Hanover, Md. 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Windame a Rocketing con Facility Sons Mortuary, P.A. Zavory 15 Rece Mo0483 821 West St. Annapolis, Md. 2 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical 23a,27 per me g910 12-27-10 vt X UNPENDED AMENDED Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Year Dav detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. Ş 1 Yes 2 No 3 Probably 4 Unknown Completed icate has been si page 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) the funeral director, 25. Was case referred to medical Division of Vital examiner? Other Nursing Home 5 Residence 6 Other: 2 No After this 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural after death. 1 Yes 2 No 5 Pending 2 Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined within 24 hours a To the Funeral I 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 2010 32. Registrar's Signature State sarke Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ hism November 6.15 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Clinton Futurecare If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XXF 78 577-42-8685 Arlington, VA **Director** Jan. Usual Residence of Decedent it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Upper Marlboro Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 20772 USA 6208 Buttercup Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: 3 🔽 Widowed 4 🗆 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bridges Agnes Paul Revmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1465 Lowell Court Crofton, MD 21114 per nit. Page 1 and 2 sh Der artment of Health ar Important: If item 27 is any injury or other trau Laura Lang 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Nov. 22,2010 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. am 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or contellications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Obstructive Pulmonary Physician/ hronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of trany, leading to infried late cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and s the burial-transit death certificate be executed Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cardionyopathy Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chronic 24a. Was an autopsy
performed?

1 Yes 2 No To the Hospital or Attending Physician: The I within "4 hours after death.

To the Funeral Director. After this certificate h completed filled in by the funeral director, page 1 Tes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioners To the best of my knowledge, death occurred at the time, data and place, and due to the class (s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

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State

Donothy 31. Date filed (Month, Day, Year)

Box 68760

P.O. I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 2 2010

32. registrar's Signature

00053337

2835 Smith Avenue Ste 203 Buthneye Md 21204

Wovember 192010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2010 COOPER JOHNNY F. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner NICOVER 544564M TENINSULA REGIONAL 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Month, Day, Months 1 💢 M 2 🗆 F MARYLAND 218-30-1182 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. But if item 27 is marked other than "natural", or items 23a or 28a-f sho tant: If item 27 is marked other than "natural", or items 52a or 28a-f sho uny or orther traumatic event, the Medical Examiner must be notified at uny or orther traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No WICOMICO WILLARDS MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21874 USA 36391 POPLAR NECK ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 🗌 No δ Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify Year or Dates. 1954-62 Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) TRUCK DRIVER BUILDING SUPPLIES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **STELLA** COOPER **GUTHRIE** DOWNS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai 8395 NEW HOPE RD., WILLARDS, MARYLAND 21874 SUE COOPER/NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/21/10 DELMAR, DELAWARE CREMATORY OF DELMARVA 21. Signature of Prince License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bleomycen

Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner nemonia Sequentially list conditions. if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of): Examine Hodgkin Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 WUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Division of Vital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Matural work? 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number M.D 057952 10/20/10

Registrar
DHMH 17 Rev 7/2009

State

106 Milford ST. Swli

Registrar's Signature

5048 . Salisbury

21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

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Babalal Das

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 17 2010 Physician/ Charles W. Collick, Sr. 4:15 A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Berlin Nursing & Rehabilitation Ctr Berlin Worcester Birthplace (State or Foreign Country)
 MD Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours Months Jan 16, 1917 1 🖳 M 2 🗆 F 217-16-9385 93 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director MD Worcester Berlin 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 604 Decatur Apts., Old Ocean City Blvd 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 x Married þ Baltimore, Maryland 21215-0036 African-1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 Divorced 4 Divorced Completed American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COLLICK, CHARLES Various Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Landia Collick မ Thom Massey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Albert B. Collick/son 9309 Seahawk Rd., Berlin, MD 21811 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State New Bethel UMC Cem 10/23/2010 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Euneral Service Licens ie Lewis N. Watson Funeral Home, 1618 West Rd isbury, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a conse ul nce of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 🗌 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work? 1 X Natural 1 🗌 Yes Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date şigned (Month, Day, Year) R 135131

Registrar
DHMH 17 Rev 7/2009

State

9715 Healthway Dr., Berlin, MD

21811

and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP,

Registrar's Signature

Pennie Savage,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend#23b.PerPhys.PGC11-23-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08 2010 рм 2:50 11 Paul Cook Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>PG Community Hospital</u> Prince Georges <u>Cheverly</u> If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Days Hours 01/03/1941 Washington, DC **Director** 69 Yrs. 579-50-3832 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 sho 10b, County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No Prince Georges Landover Hills 10e. Street and Number 10g. Citizen of What Country? Funeral 6921 Shepherd Street 20784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Support Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Cook Zellen Bynum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shepherd Street Landover Hills, MD 20784 <u> Trudy James-Cook / Spouse</u> 6921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 11/19/2010 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee Montgomery 20722 3401 Bladensburg Road Brentwood, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death ARRHYTHIMIA Physician FATAL CALDIAC disease or condition Medical resulting in death) Due to (or as a consequence of) Examine Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ADVANCED LING CANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown this certificate has been 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy XV. 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **X**0 lo Other: |은 1 🗌 Yes 1 Inpatient 2 R/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 1 Natural 28c. Injury at s after death, I Director: After t 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the cause of examination and or exa Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, beautiful during at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatury 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVIS MD HOSPITAL DUVE 3001 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

And y L. Campbell And y L. Camp			Pleas 1 - For State Registrar	se Type or Pri State of M	aryland / [)epa	delible Ink artment of I rtificate of	Health	and M	ental Hy		egible.	3852	25
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Use Resource of Decederal 10c. Clay Tomor or Location	Examir		1300 Middlene	ck Drive, A	pt. G	th do	Salisbu	ıry		9 Date of Birth		Wicon	nico	omian
Joyce Marie Campbell/spouse 14549 Sandy Lane, Eden, MD 21822 20a. Method of Disposition 18 Burial 2 20cremation 3 Removal from State 18 Burial 2 20cremation 19 Burial 2 20cremation 19 Burial 2 20cremation 19 Burial 2 20cremation 20crema	Director		Usual Residence of Decedent								, Year) 1937	l Co	ountry)	Ji eigii
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/ / / 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	CIUL SOUTH TO SOUTH T	M	(h	eme	NO		H				29d. Date	e signed (Mon	th, Day, Year)	
109 Dr. Elledy Zigmer 100 Power St Schisbury Md 21804	IVA		Dr. Elledy Zigma	•				-1:34	sury	Md	٤	1804	•	
State Registrar State NO 2 2010 State Registrar Registrar Registrar State Registrar State Registrar			31. Date filed (Month, Day, Year)	2010 28. Regist	rar's Signature	pa	skel		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 08^{ay} 20 Ye 1825 Physician/ Agnes I. Dunay Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Crofton Care and Rehab Crofton 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Hours Min. 06/14/1923 Uniontown PA Director 076-20-1530 Usual Residence of Decedent 10d. Inside City Limits ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 🗌 Yes 2 😾 No Elkridge MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21075 USA Funeral 6734 Montgomery Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 08 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) P Susan Baran Dunay George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Montgomery Road Elkridge, MD 21075 <u>Michael G. Dunay</u> Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/13/2010 Uniontown, PA St. Mary Nativity 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final WEEKS Enysician/ and disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** yeans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the sompleted filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) HowardKS chaltz

Registrar

State

31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11/10 2010 Year Physician/ Shirley Corrine Dixon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 X F Months Days Hours Min. **Director** 579-38-0908 80 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location Director MD Anne Arundel Annapolis 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 21401 844 Mission Valley Lane USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 9 ⋛ 1 Never Married 2 Married 1 Yes 2XXNo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xx No Specify: "natural" Specify. 3 XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Postal Worker other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Frank Beuchert Ruth Hooker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Dixon Son Centreville, 6300 Sharps DR. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Cedar Hill 11/16/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 Signature of Funeral Service Ricen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). physician Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown the detached 9 Unknown ģ Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 24a. Was an page performed Yes 2 Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

USPS VA 20121 20c. Location - City or Town, State Suitland, MD Approximate Interval Between Onset and Death 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Mghth, Day, Year) 016376 2010

3. Time of Death

1533

DC

10d. Inside City Limits

1 Yes 2 XNo

9. Birthplace (State or Foreign

White

Black, White, etc

Registrar DHMH 17 Rev 7/2009

State

(Check only one

and title of certifie

29b. Signatur

mpleted cause of death (Item 23a) (Type, Print)

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Charles	Dykes

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ease Type or Print in Black Indelible State of Maryland / Department o	of Health and Mental Hygiene	L	U	U	3 {	55	2

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edical Exan	nine	Gliattes A. Dykes, of.						Day Year r 28, 2010	1650 hrs
		4a. Facility Name (if not institution, give street and nur 3502 Reisterstown Road	nber)	4	b. City, Town, or Baltimore	Location of L	Deatti	Baltimo	
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yes			rth (MM/DD/YYYY) 9.	Birthplace (State or Foreign Country)
Directo	r	213-40-4501 1XM 2_F		67 yrs.	Months Day	s Hours	Min. 03/26	/1943	MD
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e, N 1 and 2 Health item 2		Amber Dykes-daughter 20a. Method of Disposition			ition (Name of ce		Date	20c. Location - City	
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Salti ermit. epartrr nports		21 Signature of Funeral Service Ligensee		22. N	ame and Address	s of Facility		uneral Hom	
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VISI or Att after de Directe in by	Certification:	Suicide Could not be	of Injury - At ho	ome, farm, stree	et, factory, office b	ouilding, etc.	28f. Location (or Town,		Rural Route Number, City
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To Wit	Mec	29b. Signature and title of certifier	ated.		29c. Licens	se number		29d. Date signed (Month, Day, Year)
(ILI)		1 M. 1	-		O.C.	M.E.		November 29,	2010
AI)		30. Name and address of person who completed cause Jack Titus MD. Deputy Chief Medica			ın Street, Bal	timore MI	D 21201		
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov 18,2010 Pay 16:17pm Anthony F Deep Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death P.G. 4b. City, Town, or Location of Death Examiner Clinton Southern Md Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Days Min. Jan 5, 1939 1 🕱 M 2 🗆 F 577-44-8951 71 Washington DC Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Clinton 10d. Inside City Limits Director Prince Georges MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 20735 11010 Welch St 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Caucasian Specify: Completed by 1 Never Married 2 Married Yes 2xx No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sheet Metal worker Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Louise Gibboney ဂ Mike A Deep 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11010 Welch St Clinton Md 20735 Nancy Deep (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 11/20/10 Date 20c. Location - City or Town, State Lee Cremetery cremetory or other place) 1 Burial 2 XCremation 3 Removal from State Clinton Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home 21. Signature of Funeral Service License 6633 Old Alexandria Ferry Rd Clinton Md 20735 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ 44 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant a Pregnant at time of death Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 X No ပု 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and titlerof certific

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 2 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month / Physician/ 1004 M Ethel R. Dashiell Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** SAUSBUL DICOMICS YENINSULA REGIONAL If Under 1 Year | If Under 24 Mrs. 8. Date of Birth (Month, Day, 5 – 11 – 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Country) Days 1 🗆 M 2 🗓 F Hours 68 MĎ Director 214-42-7527 Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2X No Salisbury MDWicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 875 Victoria Pk Dr, Apt 315 21801 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify Black "natural", Completed 3 X Widowed 4 Divorced th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filt Department of Health and Mental Important: If Item 27 is marked cary injuy or other traumatic evenne. ၉ Nora Goslee Walter A. Fooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 413 Prince Street, Salisbury, MD 21801 <u>Rahmanda Dashiell/</u>Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2X Cremation 3 Removal from State Direct Cremation, 11-29-2010 Dover, DE 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury MD 21801 Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Respirator disease or condition resulting in death) Medical as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Day Year ģ Pregnant at time of death Unknown been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has funeral director, page 2 performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28b. Time of 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manyer of Death 28c. Injury at 5 \square Pending work? 1 ☐ Yes 2 ☐ No Natural Investigation Accident within 24 hours after death

To the Funeral Director:

completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number Little of certifier 110 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21801 Alm MD

State

Registrar

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Registrar's Signature

Davis

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 49 AM -BOIL **Medical** 4a. Facility Name (if not institution, give street City, Town, or Location of Death **Examiner** Bethes monta burban If Under 24 Hrs. 7. Age (In yrs. last birthday) Sirthplace (State or F reign Country) 8. Date of Birth **Funeral** Months Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Y Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 2 2 18 Specify Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname ပ္ 1ga. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drive Germantain Method of Disposition

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser 23a. Part 1. Enter the disea le, shock, or heart failure. Lis r complications that caused the death. Do not enter only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence of): The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After it is certificate has been signed by the attending physician and completed filled in by the fineral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ☐ Yes 2 1 Mc To Be Dorsey The Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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			1 - For State Registrar	State of Marylan	-	artment of F tificate of		Mental Hy	/giene Reg. No.		
	Physic /Medi		Decedent's Name (First, Middle, La Amelia Z.	Dassinger				2. Date of De Month Novemb	Day	Year 2010	3. Time of Death 2:25 PM
	Examinum Funeral Director		4a. Facility Name (If not institution, given Hillhaven Nursing 5. Social Security Number 0.53–18–7745	g Home	last birthday) Yrs.	4b. City, Town, o Adelphi If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Prince		place (State or Foreign
	70	or	Usual Residence of Decedent 10a. State 10b. County MD Prince (- • '	y, Town or Locates			0 12			IOL K IOd. Inside City Limits 1 X Yes 2 No
	h with the P 3e or 28e-	ai Direct	10e. Street and Number 5810 33rd Avenue	2		10f. Zip Code 20782			10g. Citizen of		•
36	within 72 hours after death with the Maryland ene. then "neturel", or Iteme 23e or 28e-f ehow he Mudical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ঐMidowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	It	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	o- 14. Ra Bla Specii	ce - Americ ck, White, fy: Wh	etc.
Maryland 21215-0036	within 72 hou ene. then "neture he Mudical E	Completed	15. Decedent's E. (Specify only highest gra		(Give life. L	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wor d)	king	16b. Kind of B		dustry
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Mary	d 2 sho th and h 17 le ma treums		19a. Informant's Name/Relationship (Elmer Hamm/ Son-	**		g Address (Street					v-cec
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Importent: if Item 27 Is marked other then "neturel", or Iteme 23e or 28e-f show any Injury or other treumatic event, the Medical Examinat must be notified at ance.		20a. Method of Disposition 12 Burial 2 Cremation 3 4 Donation 5 Dother (Specification 2). Signature of Fundal Service Science (Specification 2).	Removal from State For	lace of Disposementery, crem 't Linc	Nystrom sition (Name of natory or other place oln Ceme . Name and Addre 401 Blad	tery 11/	Date 18/2010 Ort Line	20c. Location Brentwo	od, Meral	own, State M Home
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68760,	ificate be executed executed by physician and institute burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence)	uence of):						-
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ords, P.	w requires that been signed by should be dete	ρ	Part II. Other significant conditions of Dementia	ontributing to death but not resu	ulting in the un	derlying cause giv	en in Part I.	1			he cause of death?
Division of Vital Records,	@ <u></u>	Completed	25. Was case referred to medical					1 ☐ Yes	ormed? 2X No	death?	psy findings available mpletion of cause of 2 No
<u> </u>	Physicia this cert al diracte	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	3□ DOA Oth	26. Place of Dea er: 4 🕅 Nursing H		one) idence 6 □Ott	ner (Specif	(y)
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2	e Hospital or A 24 hours efter e Funerel Direc etely filled in by		4 Homicide determined	building, etc. (Specify	Medica death	personal at the tive	ra, date and place	City or To	wn, State)	annur an m	al Route Number,
	To the Ho within 24 I To the Fu completely	Medical	(Check only 2 ☐ Medical Examone) 29b. Signature and title of certifier	niner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my of	oinion, death occu	rred at the time,	date and place,	and due to	o the cause(s)
	7 × 2		230. Signature and title of certified	Heal ?	us)	29c. Licenso D0057			29d. Date signe		uay, tear)
	15		30. Name and address of person who on Njideka Udochi,	MD 9055 Chev	rolet	Print)		llicott	City, N		042
I	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 2 3 2010	32. Registrats Signar	arke						

17. Father's Name (First, Middle, Last)

Physician

/Medical

Examiner

10a. State

Director

Funerai

Completed by

Be

Funeral

Director

item 27 is marked other then "natural", or Itame 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

Hygiene.

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After this

Hospitel or Attending

death.

within 24 hours after deat To the Funerel Director:

the attending physician

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner

by Physician/Medical

Completed

Be

Certification; To

Medical

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

19a. Informant's Name/Relationship (Type, Print) Warren Kenneth Eister, Jr./Son

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Doensel

dn

11/18/10 Metropolitan Crem. Alexandria, Va. 22. Name and Address of Facility Muriel H. Barber Funeral Home P. U. Box 5036, Laytonsville, Mu.

20882

20c. Location - City or Town, State

Immediate Cause (Final resulting in death)

23a. Pyrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Acute Myocardial Infarction

Approximate Interval Between Onset and Death Immediate

Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Ischemic Cardiomyopathy Due to or as a cons uence of:

1 Year

Due to (or as a consequence of)

m-00470

Due to (or as a consequence of):

IF FEMALE

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

25. Was case referred to medical

29b. Signature and title of certific

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 4☐ Pregnant at time of death

9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

23e. Did tobacco use contribute to the cause of death?

Year

Assisted

Living

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Type II Diabetes Mellitus

24a Was an autopsy performed?

1 ☐ Yes 2 🖾 No

3 Probably 4 Unknown

2 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

November 17, 2010

examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury

1 Matural 5 Pending 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of pers in who completed cause of death (Item 23a) (Type, Print)

18109 Prince Philip Dr., #200, Olney, Md. 20832

D 0035045

State Registrar

M.D. Philip G. Henjum, 32. Registrar's Signature 31. Date filed (Month, Day, Year) 0 Rosessan

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DHMH 17 Rev 1/2001

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Daniel Gerald	Ellis

iel Gerald	Ellia	Please Type or Print in Black Indelible		Legible.
iei Geraio	EIIIS	State of Maryland / Department 1- For State Certificate		2010 38534
Physic	ian/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date	Reg. No. of Death 3. Time of Death
dical Exan		Daniel Gerald Ellis	Month Nove	
)		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		Washington County Hospital	Hagerstown	Washington
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		e of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Was t
Directo		219-52-1820 1XM 2 F 61 Y	rs. Months Days Hours Min. Mar	ch 8, 1949 Country Virginia
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death with the Maryland or items 23a or 28a-f show	<u> </u>	18829 Shepherdstown Pike 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	21756 Vas Decedent of Hispanic Origin? (Specify Yes	U.S.A. or No- 14. Race - American Indian, Black,
eath v item	Funeral	1 Never Married 2 X Mamied Armed Forces?	Yes, specify Cuban, Mexican, Puerto Rican, et	
fter d	by F		Yes 2X No specify:	Specify: White
2 hours afte "natural", Examiner	b b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent during	ent's Usual Occupation (Give kind of work done most of working life. DO NOT use retired)	16b. Kind of Business/Industry
6 n 72 h	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	,	
5-0036 led within 7. Hygiene. other than	Completed		em Administrator	Computer Technology
11215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene. Are restricted other than "natural", or items 23a or 28a-f showers, the Medical Examiner must be notified at one very.	Be C	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Mi	,
T 5 6 4 5	To B	Fred Gerald Ellis 19a. Informant's Name/Relationship (Type, Print) 19b. Maili	mg Address (Street and Number or Rural Rou	Ouise Whittington te Number, City or Town, State, Zip Code)
and 2 shou lealth and N tem 27 is n traumatic	-		29 Shepherdstown Pike	
ore, ME ssland2s of Health as If item 27		20a. Method of Disposition 20b. Place of Disp	osition (Name of cemetery, Date	20c. Location - City or Town, State
Baltimore, permit. Pages 1 and Department of Heal Important: If item injury or other tra		T David 2 A Grenation 5 Tremoval from State		010 Frederick, Maryland
altin mit. partm ports		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Bast-Sta	auffer Funeral Home, PA
E E A E in	6 10	THELLER NUCLE 176	606 Old National Pike	Boonsboro, MD 21713
Physician /Madies		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each libe.	the mode of dying, such as cardiac or respirato	ory arrest, shock, or heart Approximate Interval Between Onset and
/Medica Examine		Immediate Cause (Final disease a Multiple Injuries complicating Car	diomegaly with Atherosclerotic Card	liovascular Disease Death
		or condition resulting in death) Due to (or as a consequence of):		
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated		
ted f	Exa	events resulting in death) Last Due to (or as a consequence of):		
executed an and al - transi	cal	d. UNPENDED AMENDED		
60, ate be hysici	Ned	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
687 ertifica fing p	sician/Med	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnancy	Month Day Year
OX (sath ce attence or use	sici	Prognant at time of death	Other (Specify)	_
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Phys	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
P.C ss that gned e deta	þ			Yes 2 V No 3 Probably 4 Unknown
ds, equire	ompleted		24a.	Was an 24b. Were autopsy findings available
COT e law r e has b e 2 sh	ם			autopsy prior to completion of cause of performed? death?
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Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be rs after death. "I Director. After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the bur.	Be	examiner? Hospital:	26.Place of Death (Check only one) nt 3 DOA Other Unusing Home	5 Residence 6 Other:
of V ing Phy After th	-	Tes Z 140	Injury 28c. Injury at Work? 28d. Des	cribe how injury occurred
Division of ' pital or Attending Ph ours after death. reral Director: After t filled in by the funeral	ertification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Xear) Nov 24, 2010 28b. Time of 0721 hrs	1 Yes 2 ✓ No Driver a	uto collision
ivision or Attent after death Director:	fica	2 ✓ Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str		tion (Street and Number or Rural Route Number, City
Dital ours at seral D	ert	4 Homicide determined (Specify) Interstate/Express	eastbour	own, State) nd I-70 east of Bower Avenue, Hagerstown, MD
Hos 24 h Fur tely	cal C	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occ		
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or investig and manner stated.		
	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		und	O.C.M,E,	November 26, 2010
1-15		Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 21201	
13		AND RUDIO MID. AGGISTANT MEGICAL EXAMINED TITLE	Outout, Dalamore, MD 2 1201	

State Registrar DHMH 17 Rev 1/2001

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Elizabeth Dawn Early 2010 8:30 A Medical Decembe 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 15009 Sabillasville Rd. Thurmont Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Washington D.C 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days July 16,1943 1 🗆 M 2 🗔 67 Director 578-56-5073 Usual Residence of Decedent ms 23a or 28a-f show must be notified at ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If it flew 22, is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Frederick Thurmont 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 15009 Sabillasville Rd. 21788 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced þ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Frederick Co. Govt. 4 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Ivanline E. Coultas ည David Early 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8435 Hemler Rd. Thurmont, Md. 21788 Wanda L. O'Brien (Friend) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg, Md. Smithsburg Crematory . Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home M01414 Smithsburg, Md. 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ntracran Medical resulting in death) Due to (or as a consequence of) Examine romere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year 9 🗌 Unknown g 🗌 Unknown ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify) Certificate: To 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28h Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print Frederick MV. 21702 MID 31. Date filed (Month Registrar's Signature State 8 2010 Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland 2008 110 entry of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ DASSAM Ford Son Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Gilchrist Hospice Towson. 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Hymer 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. $\int an^{Month 3^{Day}} 1940$ 1**X** M 2 □ F GA 70 260-56-8874 Director Usual Residence of Decedent fshow 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State Director XX Yes 2 No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21042 9047 Dunloggin Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 1980 White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Certified Public Accountant Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Louise Elizabeth Carter John Thomas Ford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 9047 Dunloggin Rd. Ellicott City, MD Wife Constance Ford 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【其Cremation 3 ☐ Removal from State Ardent Cremation Ser. 11/18/2010 | Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facil Harry H. Witzke's Family FH, Inc. K A112 Old Columbia Pike Ellicott City, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Ph√sician/ disease or condition resulting in death) Medical Due to (o a a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate outco. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Day Month Year 2 No 1 ☐ Yes 2 ☐ Unknown To the Hospital or Attending Physician; The law requires that the within 24 hours after death.

To the Funeral Director, After this certificate has been signed by to completed filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) potent 1 ☐ Yes 2 KNo 1 Inpatient 2 ER/Outpatient 3 DOA 욘 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 \square Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) R125808 V24 Vee-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sf

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

10-09123 Karen Sue Fletcher Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar				Certific	cate of	Death			Re	g. No.		
Physicia		n/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Pay Year									3. Time of Death			
Medical Exami		Karen			Sue		F1e	tcher			November	28, 2010 Year		1233 hrs
		4a. Facility Name (i	f not institutio	n, give street an		-	41	o. City, Town, or	Location	of Death		4c. County of		
		640 Oak Hil	I Avenue A	Apt 2				Hagerstown	1			Washing	ton	
Funeral		5. Social Security N	lumber	6. Sex	7. Age (In yrs. last bi	rthday)	If Under 1 Yea		er 24Hrs.	8. Date of Birt	h(MM/DD/YYYY)		hplace (State or Foreign intry)
Director		216-76-2	445	1 M 2X	F 5	3	Yrs.	Months Day	s Hours	Min.	Sept.	18,1957		aryland
		Usual Residence of	Decedent							-1	1			
, any		10a. State	10b. County		10	c. City, Town	n or Locatio	n					ĺ	10d. Inside City Limits
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Baltimore, MD 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fleath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-fahe injury or other traumatic event, the Medical Examiner must be notified at once		21 Signature of Full	neral Service	Licerisee			22. Na	me and Address	s of Facility	Rest	t Haven	Funeral	Cha	apel
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x 6 th cer ttendi	icia			nown 4 Pr	egnant at tim		\equiv	er (Specify)						
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on of	nding Pri ath. : After thi e funeral o		27. Manner of Death 1 Natural 5 Pend 2 Accident Invest	28a. Date of inj	ury	28b. Time o injury		28c. Injur work	y at	28d. Describe h			
Divisio	al or Atters as after deal Director	Certificate:	3 Suicide 6 Could 4 Homicide deten	28e. Place of In	jury - At ho tc. (Specify	me, farm, str	eet, factor	y, office		28f. Location (S City or Tow		mber or R	ural Route Number,
- ,	to the hospital of Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s	Medical	(Check 2 Medical only one) 3 Certifyin	ng Nurse Practioner: To the	examination	and/or inves	tigation, in death occu	my opinion rred at the	on, death occurred time, date and plant	at the time. date a	nd place, and e cause(s) and	due to the manner a	cause(s) and manner stated s stated.
	North To the		29b. Signature and title of certific	er				c. Licens 0091	e number 57		29d. Date sig		th, Day, Year)
				n who completed cause of				24	W 3rd S	t Cumb	erlan	d MD	21502
	Sta Registr		31. Date filed (Month, Day		ar's Signat			Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARY VIRGINIA GALLOWAY NOVEMBER 11:40 A M 19, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year) | Min. | MAY 9, 1925 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 85 Yrs. MARYLAND 220-22-7186 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f showing the Mudical Exercises round be notified at 1 X Yes 2 □ No MARYLAND HARFORD HAVRE DE GRACE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 301 STRAWBERRY LANE, APT 9 21078 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NANNY PRIVATE HOME permit. Pages 1 and 2 should be filed w Department of Heelth and Mental Hygier Important: If item 27 is marked other th any njury or other traumatic svant, tha once. 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NORMAN PARSON GOLDIE RICHARDSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WOODLIT B. RICE / SISTER 800 PARK DRIVE, HAVRE DE GRACE, MARYLAND 21078 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. JAMES UNITED CEM. 11/27/10 HAVRE DE GRACE, MD 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME P.A.
552 LEWIS STREET, HAVRE DE GRACE, MD 21078 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bilateral Physician neumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Due to (or as a consequence of) 6. Box 68760 attending physician for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Bilateral Lung masses, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown Breast Cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificete 1 Yes 2 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٢ this 28a. Date of Injury (Month, Day Year) After the 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation ivision 1 ☐ Yes 2 ☐ No death. М 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide within 24 hours a To the Funeral (LE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier Klupan 045344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Name and address of person with January Jan 622 S. UNION AVE, HAVRE DEGRACE, MB21078 31. Date filed (Month, Day, Year)
NOV 2 3 2010 State Registra

38540 State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician. 2010 Month NOV 17 ARTHUR MICHAEL GROSS 2:42 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5 Social Security Number 7. Age (In yrs, last birthday) Funeral 1 XM 2 □ F Days Min. 470-28-4679 Yrs Director 79 Minnesota Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 🗆 Yes 2 ื No MD Prince George's Bowie 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 13209 Martha's Choice Circle 20720 USA ral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Year or Dates. 1950 - 69 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: "natural", Specify. 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Cryptologic Technician 12 U.S. Navy other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Loretta Nagel Alex Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 13209 Martha's Choice Circle, Bowie, MD 20720 Dorothy E. Gross / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🗀 Cremation 3 🗖 Removal from State 4 ☐ Donation 5 ▼ Other (Specify Entombment Gate of 11/20/2010 Heaven Cem. Silver Spring, MD of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home Bowie, MD 6512 NW Crain Hwy., Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ METASTATIC CARCINOID CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death
9 Unknown Month Day Year Yes 2 No ed by the a 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 🗌 No 1 Yes Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 Q No 1 Yes Certificate: To 1 Annual Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) : After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 1 Natural 5 Pending within 24 hours after death, To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 7NOV 2010 0101243094 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER MC USN ANDREW I. PHILIP LTBETHESDA MD 20889-5600 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 8 2010 NOV 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-0	9243		Please Type or Print In	Black Inde	elible Ink	. Ensure	All Copies	s Are Leg	ible.	
Felic	e B Goldste		State of Maryla	nd / Depart	ment of F	łealth and	d Mental Hy	giene	20 :	10 38541
	Physicia	an/	egistrar i. Decedent's Name (First, Middle,Last) Felice B. Goldst			-		2. Date of Death Month December		3. Time of Death 1832 hrs
	al Exami		ta. Facility Name (if not institution, give street and nu				Location of Death	December	4c. County of I	
	Funeral	4	Anne Arundel Medical Center 5. Social Security Number 6. Sex	7. Age (In yrs. last		Annapolis If Under 1 Year		8. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State or foreign
	Director		212-90-0194 1 M 2 KF	40	Yrs.	Months Days	Hours Min.	04/02/	1970	Country) PA
	any		Jsual Residence of Decedent 10a, State 10b, County		own or Location					10d. Inside City Limits 1 Yes 2 X No
C	yland •-f show	jó	MD Anne Arunde1 10e. Street and Number	An	napolis	Of, Zip Code		10	g. Citizen of What	
1436	the Mar 3a or 28a	Dire	884 Coachway			214			USA	A Indian Block
7	death with the Maryland or items 23s or 28s-f show must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 1 Yes	edent Ever in U.S. prces? 2 No	If Yes	, specify Cuban —	panic Origin? (Spe , Mexican, Puerto F	ecify Yes or No- Rican, etc.)	White,	
	s after d ral", or	<u>ā</u>	3 Widowed 4 Divorced If Yes, Give Yea or Dates: 15. Decedent's Education (Specify only highest grades)	r			specify:	ork done	Specify: W	
	5 72 hour 11 "natu cal Exan	leted	Elementary/Secondary (0-12) College (1		during mos	t of working life.	. DO NOT use retire	ed)	Educat	ion
	d within ygiene.	Completed	17. Father's Name (First, Middle, Last)				18.Mother's Name		aiden Surname)	
	21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Jeffrey Goldstein 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing A	Address (Stree	Robert et and Number or R	a Koza		State, Zip Code)
	MD 2 d 2 shoul lth and N n 27 is n	To	Roberta Goldstein/Moth		884	Coachwa	ay, Annap	olis,MD	21401	ity or Town, State
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deparment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a, Method of Disposition 1 X Burial 2 Cremation 3 X Removal fr	om State cre	ematory or othe	r place)		/05/2010		gton,DE
	Baltimore, permit. Pages 1 an Department of Hee important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Nicholas Picollelli	00788 per DV	m Sch	me and Address	2 Memoria	1 Chape	1, 519 P	hiladelphia
	©hysician		23a. Part I. Enter the disease, or complications that of	aused the death. D	o not enter the	ke, Wi mode of dying,	such as cardiac or	respiratory arre	st, shock, or hear	t Approximate Interval Between Onset and
	/Medical Examiner		Immediate Cause (Final disease a Asthm	a complication consequence of):			done and	Cocaine	2	Death
		L	Sequentially list conditions, b	consequence of):						
		amine	cause. Enter Underlying Cause (Disease or injury that initiated	a consequence of):						
	scuted and transit	m	d			011 455	M1/14/20	11		
	60, tte be excharged by sician e burial -	Medic	UNPENDED AMENDED IF FEMALE: 23c. If yes,	#21 per #23a,27,2 outcome of pregna		er me,g	01/14/20 912,02/0	<u>1/2011dl</u>	23d. Date of d	
	Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	oirth nant at time of dea	2 []	I death 3 er (Specify)	Ectopic pregna	ncy	Month	Day Year
	the death y the atte	Physi	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to	own o death but not res			given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
	, P.O. res that signed b	d b						1 12 12	2 ✔ No 3	
	of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execut. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - trait.	Completed						24a. Was autop perfor	sy pr m <u>ed</u> ? de	ere autopsy findings available for to completion of cause of eath?
	l Rec n: The l rtificate or, page	e Co	25. Was case referred to medical			26.Place	e of Death (Check	1 Yes	2 No 1	Yes 2 No
	n of Vital ling Physician: After this certif funeral director,	T B	examiner? 1 ✓ Yes 2 No 27. Manner of Death 28a. Date		ER/Outpatient 28b. Time of In		Other Nursin		Residence 6	
	Division of Vital Records, P.O. tall or Attending Physician: The law requires that the rest after death. **ab Director** After this certificate has been signed by led in by the funeral director, page 2 should be detach	tion:	1 Natural 5 Pending 12/0	hdPey,Year) 01/10	Found a 6:06 p.	m. 1	Yes 2 No	_	t took d	
	Divisi al or Att s after de al Direct ed in by	Certification:	3 Suicide 6 Could not be determined (Specify	ce of Injury - At hor Subject	me, farm, street	, factory, office an aut	building, etc.		tate) Rr 2	or Rural Route Number, City West Street
	Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the Pi	ial Ce	29a. Certifier (Check only 1 Certifying Physician: To the be	est of my knowledg	e, death occurr	ed at the time, d	date and place, and	I due to the caus	se(s) and manner	as stated. ue to the cause(s)
4	To the within To the complete	Medical	one) 2 Medical Examiner: On the basis and manner 29b Signature and title of certifier	stated.	7 X		nse number			d (Month, Day, Year)
			Tuto Valler Ve	ed !	**	0.0	.M.E.		December :	2, 2010
		100	30. Name and address of person who completed car Victor Weedn MD JD Assistant M	use of death (Item edical Examin		enn Street, I	Baltimore, MD	21201		

State 31. Date filed (Month, Day Year)
Registrar OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November P^{M} Sadie Smith Griffin 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Solomons Nursing Center Solomons 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, **Funeral** Hours 1 □ M 2 🔀 F 1070971919 North Carolina Yrs 91 Director 244-32-2883 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 Yes 2 No Port Republic Calvert Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 2870 St. Leonard Road 20676 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 2 2 No ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) School Cafeteria Food Preperation 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Helen Barrington William David Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6015 Bay View Road, St. Leonard, MD 20685 Shirley Waddell/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11/18/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 600, Lusby, Maryland 20657 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregna☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Dav Pregnant at time of death 1 Yes S s been signed by the s should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown icate has been s r, page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of My Sillan D58572 November 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JRW 110 Hospital Road, Suite 310, Prince Frederick, Maryland 20678 Gwyneth Anne Blattau, MD

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Tom Graham Physician/ Nov 16 2010 6:30 **a** M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hyattsville 7901 Kreeger Drive #107 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8 Date of Birth 7. Age (In vrs. last birthday) Funeral Days Hours May 9 1942 1**X** M 2 □ F 242-58-9419 North Carolina Director 68 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified t**x** Yes 2 ☐ No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7901 Kreeger Drive #107 20783 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene.

is marked other than Page 1 and 2 should be filed within iment of Health and Mental Hygiene. Eart: If item 27 is marked other thar ury or other traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Entrepreneur 8TH Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Azor Graham Maggie Applewhite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1415 Southern Avenue #103 Oxon Hill, Maryland 20745 Bettina Simmons/Dgt. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or other cemetery, crematory or other place. 1 Burial 2 X Cremation 3 Removal from State
4 Donation 5 Other (Specify) 11/20/2010 Riverdale, Maryland Riverdale Crematory J. B. Jenkins Funeral Home, Inc. Signature of Funeral ervice densee 22. Name and Address of Facility 7474 Landover Road Hyattsville, Maryland 20785 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ disease or condition Medical resulting in death) o (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or Imjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 the ast attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Year Month 5 Other (specify) Pregnant at time of death 2 No s been signed by the should be detached 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autons page Yes 2 No this certificate Yes 2 No Division of Vital 25. Was case referred to cal funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Tyes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4
Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred work? Natural injury 5 Pendina after death. Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined building, etc. (Specify) 24 hours a Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29h. Signature and tifle of certifle 29c. License number

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State Registrar Jaon

31. Date filed (Month, Day, Year)

NOV 2 3 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month TERESA GILMORF November 12:34 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Chaconia Assisted Living Bowie Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Days Country) Coffeyville, KS Months Hours Min Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County iral", or items 23a or 28a-f shore Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Anne Arundel Pasadena 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 106 Chelsea Grove Court 21122 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Black "natural", 3 Widowed 4 □ Divorced Specify: Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) event, the Music Teacher D.C. Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. Russell Cartwright Eliza Joyner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kesha Gilmore (Daughter) 4019 21st St. NE Washington, DC 20018 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Fort Lincoln Crematory 11/19/2010 4 Donation 5 Other (Specify) Brentwood, MD 21. Signature of Funer Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home axces 3401 Bladensburg Rd. Brentwood, MD 20722 Part 1. Enter the cise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fi disease or condition resulting in death) Physiciani MINMA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day signed by the a d be detached t 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 W Unknown been si should l 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 to Other (Specify) assisted (IVIN 2 🖪 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA hin 24 hours after death.

the Funeral Director: After this impleted filled in by the funeral dii 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred Natural Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29d. Date signed (Month. Dav. Year. WAMUENAY 11-18-10

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day OZ ZOID Physician/ Walter Charles Good O'cember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Months 1 □ M 2 □ F Sept. 4, 1944 Mary and 66 Director 212-50-8272 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington Hagerstown Md. 1 🗆 Yes 2 🛶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 U.S.A 12816 Beck Rd. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by 2 X No 1 ☐ Yes 2 If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Greenhouse/Landscaper Horticulture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Genevieve Semiler Walter J.T. Good 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Barbara Susan Good (Wife)</u> 12816 Beck Rd. Hagerstown, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Dec. Smithsburg, Md. 4 ☐ Donation 🕭 ☐ Other (Specify) Smithsburg Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home MO1414 Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition ewtua Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lot as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **1**No Other: မ 1 Inpatient 2 R/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Ratural 1 Natural 2 Accident 5 \square Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined hours after City or Town, State, within 24 hours a Medical 29a. Certifier 1 Descripting Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, accurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wuseem Muhammad MO

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State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month BARBARA 2010 Physician/ HANTSKE 1720 M Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Annapolis Pinkney Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Mary Land 1 M 2 F 215-28-1622 79 Yrs. **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Annapolis Maryland Anne Arundel 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21401 Funeral 6 Pinkney Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 XNo þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done (life. DO NOT use retired) during most of working (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) County Court Director of Assignment Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, Charlotte Cora Miller ည Robert Franklin Dudrow 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2900 Chestnut Rd, Edgewater, MD 21037 19a. Informant's Name/Relationship (Type, Print) Robin Ward - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Fort Lincoln Crematory 11/16/2010 Brentwood, MD 4 Donation 5 Other (Specify) John M. Taylor Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility 147 Duke of Gloucester St, Annapolis, MD 21401 W Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_sician/ UNG disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying
Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician; The law requires that the death certificate be executed for use as the burial-tran the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 2 No detached g Unknown ss been signed by the should be detached Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an has h autopsy performed? prior to completion of cause of page 2 death? 1 Yes 2 No certificate completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) ဂ္ 1 🗌 Yes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 Natural 5 Pending 1 Tyes 2 🗌 No 24 hours after death Funeral Director: A Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in the basis of examination and or investigation and or investigation a Medical 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 3 [only one) 29b. Signature and title of certifie mpered cause of death (Item 23a) (Type, Print) 30. Name and address of person wh gistrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Pepartment of Health and Mental Hygiene (12/2011dhb) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 6: 45 P M WILLIAM HENRY HOLLAND ,2010 NOVEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARROR HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 30 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign ^{Year)} 958 **Funeral** Days Hours Months 1**X** M 2□ F Maryland 219-74-1267 Mar 52 **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinational behalffed at 1 ☐ Yes 2 X No Directo Marvland Anne Arundel Annapolis 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 1106 President St. 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exemplanone. Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2**X**□No þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Self Employed Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James A. Holland Jr Martha Simms ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henrietta Diggs(Sister) 332 Presstman St. Baltimore, Md. 21217 2015. Olacenof Listen story of Alame of cemetery. Crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11-12-10 Annapolis Neck Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Williame Rease of AciliSons Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 Lavy D. Been MO0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): ASPIRATION AMECMONIA Examiner Embousm PULMONART Sequentially list conditions, if any, leading to ininiediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last APPROVED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of) and burial-tran Due to (or as a consequence of): CERTIFICATION Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 □ Yes 2 □ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> KIDMEY IMSUR' 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown ACUTS. Completed MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? DIABETES 24a. Was an autopsy performed? 1 □Yes 2 ☑No certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner?
1 Yes 2 No. funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or Attending Within 24 hours after death. To the Funeral Director: After 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES -001 NOVEMBER 11 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAINI, 3001 SOUTH HAMOVER STREET, BALTIMORE MO -21225 31. Date filed (Mont NOV 17)6 2010 Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ Margaret Jane Hartnack 2010 2:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5500 Baskin Street Churchton Anne Arundel Social Security Number 7. Age (În yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) April 14,1931 New Jersey 1 □ M 2 🂢 F 79 Director 152-26-2625 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director Churchton MD Anne Arundel 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20733 USA 5500 Baskin Street 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 ☐ Never Married 2 😾 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mildred Hedden James Edgar Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Edward T. Hartnack / Husband 5500 Baskin Street Churchton, MD 20733 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. Baltimore, MD 2010 21. Signature of Europa Service Licenses 22. Name and Address of Facility CREMATION DIRECT 495 Ritchie Hwy. Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician zernmer + year disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗀 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Acciden 5 \square Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Nev. 11, 2010 D0040909

Registrar
DHMH 17 Rev 7/2009

State

ANNAPOLIS. MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan	•				and Me	ental Hy	giene	10	2051.0
			Registrar	-41		Cer	tificate	of D	eath			Reg. No.	IU	38549
	Physicia	ın/	1. Decedent's Name (First, Middle, Last Jerry G.	•	4911					1	Date of DealingMonth	Day	Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give	C IC C	1411		4b. City, To	we or l	ocation of	of Dogath	11		3010	5:45 PM
	Examin	lei	0 1 (1)	e at the	. (ike			bun				ty of Death	` 6 0
	Funeral		5. Social Security Number 6. S	ex 7. Ac	e (In yrs. la	ast birthday)	If Under 1	Year	If Under 2	24 Hrs. 8	3. Date of Birt	Ho	G. Birth	place (State or Foreign
	Director		209-21-0279	№ M 2 🗆 F	78	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year) 1931	Mar	yland
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	arylan a-f sh fied a	Director		4	100. 010	Crist								10d. Inside City Limits 1 ☐ Yes 2 💆 No
	or 28	ă	Maryland Somers 10e. Street and Number	Set		C 1737	10f. Zip C	ode				10g. Citizen o	f What Cour	•
-	with t	Funeral	3531 Freedom	town R	d				817			-	S.A.	•
	tems er m	Ę	11. Marital Status	12. Was Decedent	, ,	S. 13. V	Vas Deceder			in? (Specif	y Yes or No- can, etc.)		ice - Americ	
စ္က	fterd , ori	ğ	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give	No		Yes, specify			, Puerto Ri	can, etc.)	1 0	ack, White,	
ĕ	tural'	Be Completed	3 Widowed 4 Divorced	Year or Dates.								Specif	y Blac	cK
7	72 ho n "na fedio	ng n	15. Decedent's E (Specify only highest gr			(Give F	lent's Usual (aind of work of ONOT use re	done du		of working		16b. Kind of	Business In	dustry
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2	iled v Il Hyg othe vent,		17. Father's Name (First, Middle, Last)							er's Name (First, Middle,	Maiden Sumar		
<u>/a</u>	d be f Venta arked itic el	₽	William	Jones						Ma-	zie	Ha 11		
an	shoul and b is ma		19a. Informant's Name/Relationship (T									r, City or Town,		
)ν. Σ	ind 2 lealth m 27 her tr		Janet M. Hall -	wife					m to w	on Ro	l. Cr	isfield,	mel a	71817
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. By 1 in a 1		20a. Method of Disposition 1 → Burial 2 — Cremation 3 —	Removal from State	C	lace of Disposemetery, crem	natory or other	er place)	Dat	- 1	20c. Location	•	<i>'</i>
ţ.	it. Pag rtmer rtant njury		4 🖸 Donation 5 🗆 Other (Special	5y)	Hope	ewell v.	m.c. Ce	mete	ry	11/2	0/10	Crist . Wan	ield,	md
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licens			22	Name and	Address	of Facility	Anti	rony E	. Wan	d F.H	
_			23a. Part 1. Enter the disease, or com	$\overline{}$	d the death								, 210	Approximate
D	h sician/		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lin	e.									Interval Between Onset and Death
7	Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	ence of:	AN	A	CC/1	DENT			-	
1	Examiner	l.		b. Cithon Due to (or as	vic	KIDI	NRI	01	S R.A.	512	571	ACR T	5	
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):			-					_
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	ate be executed obysician and the burial-transit	alE	resulting in death) Last	Due to (or as	a consequ	ence of):								
90	dearn cerrilicate be executed to attending physician and set for use as the burial-transit	edical		d									+	
P.O. Box 687	attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								224 5	ate of deliv	07/
ŏ	earn c atter	icia	in the past 12 months?	1 Live Birth 4 Pregnant a			Ectopic pre Other (spec						lonth	Day Year
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<u>a</u> .	requires mar the de been signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death b	out not resu	ulting in the u	nderlying cau	use give	n in Part I.		23e. Did to	obacco use cor	tribute to th	he cause of death?
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æ 🖁	cate l										1 🗆 Yes	2/ No	death?	27 No
ta	rnysician: r this certifica aral director, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:				Lou		h (Check oi	nly one)	-		
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n N	ath. ? Afte e fune	icat	Natural 5 Pending 2 Accident Investigation	(Month, Da	y, Year)	injury	м 200	work?	es 2 🗆 l	- 1	a. Describe ii	low injury occur	ica	
Division of Vital Records,	al or Attendir s after death. al Director: Af ad in by the fu	Certificate:	3 Suicide 6 Could not b	e 28e. Place of Inju	ury - At ho	me, farm, stre	et, factory, o	ffice		28			ber or Rural	Route Number,
	Irs aft al Dii led in			building, et							City or Tow			
9	To the respitate or Attending Prysician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier Certifying Physical Check 2 Medical Exami	ner: On the basis of e	xamination	and/or investi	igation, in my	opinion.	, death occ	curred at th	e time, date a	nd place, and d	ue to the car	use(s) and manner stated
4	ithin 2	ž	only one) 3 Certifying Nurs	se Practioner: To the	best of my	knowledge, d	eath occurred	d at the t	time, date a	and place,	and due to the	e cause(s) and n	nanner as st	ated.
•	- ≯≓ŏ									110		29d. Date sign	17/	vay, rear)
,	XCF		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type. P	ー <u>ーリ</u>		07	10			1/10	
	0		Cottum was	to P.S	BOT	0 17	733	SA	us,	110 Bui	yu	up 2	180	2
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Registrar DHMH 17 Rev 7/2009 10-08801

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Donald Cortez Hales 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 16, 2010 1759 hrs al Examiner Hales Donald Cortez 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Upper Marlboro 1 Rosebud Court 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5, Social Security Number **Funeral** Min. Hours Months Days Director 02/15/1935 1 X M 2 F Washington, DC 75 578-48-8092 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No 28a-f show s 23a or 28a-f show e notified at once. Baltimore, MD 21215-0036
pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once-Prince Georges Upper Marlboro 10g. Citizen of What Country 10e. Street and Number 20772 Rosebud Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes 1956-1958 4 Divorced Yes 2 X No specify: Specify: **Black** 3 Widowed à 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Specialist Federal

18.Mother's Name (First, Middle, Maiden Surname) Video Archive 17, Father's Name (First, Middle, Last) Be Ida Mae Mundy Joseph Hales 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9010 Briarcroft Ln Apt. Laurel. MD 20708 Cynthia <u>Hales - Spouse</u> Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetery 11/27/2010 Brentwood, MD Donation 5 Other Specify 22. Name and Address of Facility Ft. Lincoln Funeral Home, 21. Signature of Funeral Service Licensee Partil. Enter the diseal, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line. Brentwood. **Physician** Between Onset and Death Medical a. Contact Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Day Month 2 Fetal death 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ੬ Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other: Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Subject shot self Nov 16, 2010 1742 hrs 1 Natural 1 Yes 2 ✔ No Pending Director: Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Dire Could not be 3 🗹 Suicide or Town, State)

1 Rosebud Court, Upper Marlboro, MD determined (Specify) residence 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 17, 2010 O.C.M.E. 0 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD 32. Registr s Sign State Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death / Month Year Physician Iseminger 10:33 P M November _indq 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗓 F 70 Oct 11, 1940 Nebraska Director 508-50-3357 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 😿 No Director Maryland Washington Keedysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 3020 Chestnut Grove Road U.S.A. Funeral 21756 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes Z 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Specify: 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Boyd Leonard Schmidt Vivian Adele Stone ဂ္ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jerry Lee Iseminger 3020 Chestnut Grove Road Keedysville, MD 21756 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. ò Stauffer Crematory 11-27-2010 | Frederick, Maryland 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 21. Signature of Funeral Service Licensee 162 7606 Old National Pike Boonsboro, MD 23a. Part 1. Egrer the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enal failure
Due to (or as fconsequence of) **Physician** Enal /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Du to (or as a consequence of) nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events ustending resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Day Year ate has been signed by the atter page 2 should be detached for 5 Other (specify) Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ Yes 2 No 1 Yes 2 46 this certificate Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 Inpatient 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 Yes 2 📑 No 2 FR/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? re Hospital or Attending Pl n 24 hours after death. re Funeral Director; After th Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Thomicide City or Town, State) 29a. Certifier 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel To the within 2

54-4-4

AMASINGHE 31. Date filed (Month.

29b. Signature and title of certifier

30. Name and addi

person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

November

29d. Date signed (Month, Day, Year)

24

2010

State Registrar 29c. License number

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar			epartment of I Certificate of I			giene Reg. No. 0	0	38552
	Physici Med		1. Decedent's Name (First, Middle Carl Carro	' '				2. Date of Dea Novembe		oyîro	3. Time of Death 2:10 a M
đ	Exami		4a. Facility Name (if not institution Mallard Bay				r Location of Deat	th	4c. County	of Death	
	Funera		5. Social Security Number	6. Sex 7. Aq	e (In yrs. last birthd	ay) If Under 1 Year	ambridge If Under 24 Hrs	8. Date of Birth		9. Birthp	ester lace (State or Foreign
	Director		214-34-5573 Usual Residence of Decedent	1 <u>x</u> M 2 □ F	73 Yr	s. Months Days	Hours Min.	May 4,	1937	Mary	vland
5	aryland a-f sho fied at	ctor	10a. State 10b. County MD Dor	chester	10c. City, Town o		dison			10	Od. Inside City Limits
χ	a or 28 be noti		10e. Street and Number			10f. Zip Code		1	10g. Citizen of W	hat Count	1 ☐ Yes 2 No
3	ath with ems 23 r must	Funeral Director	1056 Taylors	Island Road	Syor in LLS	12 Wes December 511	21648		USA		
Maryland 21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. 2d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	ried Armed Forces?	No 1960–66	13. Was Decedent of H	n, Mexican, Puert	pecity Yes or No- to Rican, etc.)	14. Race Black Specify:	- America , White, e whi	tc.
215-(רסל 72 אסן an "nat Medica	mple	(Specify only highe	nt's Education est grade completed)	(G	ecedent's Usual Occup ive kind of work done of b. DO NOT use retired)	ation luring most of wo	rking	16b. Kind of Bus	siness Ind	ustry
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Man	2 should the and 1 the and 1 to a trauma		19a. Informant's Name/Relationsh Kay Abey	nip (Type, Print) Sister	19b. M	ailing Address (Street a	and Number or Ru	ral Route Number,	City or Town, Sta		ode)
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Baltimore,	permit. Page 1 and Department of Huportant: If ite any injury or ot once.		4 ☐ Donation 5 ☐ Other (S 21. Signatur Aff Funeral Service L	pecify)	pld Trin	ity Church	yard 11	/15/10	Church	Cre	ek, MD
B	permi Depar Impo any ir		the long			22. Name and Addres	t St., C	ambridge.	, MD 21	е Р. 613	Α.
	Medical Examiner	er	23a. Part Y. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Socurability fist conditions, if any, leading to immediate	a. PRO Due to (or as a 1 RR	RESIVE consequence of:	NEURODE	GENERATI HEXIA		order		Approximate Interval Between Onset and Death
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3760	cate be executed physician and the burial-transit	ledical E	resulting in death) Last	Due to (or as a d	consequence of): ATE CA	NCER WITH	BLADDI	er outlet	OBSTRUCT	hoi	
Division of Vital Records, P.O. Box 687	.= - 0)	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	Petal death	B			23d. Date Monti		/ lay Year
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Vita	lysician is certif directol	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	nt 2 🗆 ER/Outpat	045	ce of Death (Chec				
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INISIO	or Atten after deal Director: in by the	Certificate:	2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could not determine	ot be	y - At home, farm, s (Specify)	M 1 Y	es 2 🗆 No	28f. Location (Stre City or Town,	eet and Number o	or Rural Ro	oute Number,
<u> </u>	nospital 24 hours Funeral sted filled	Medical	(Olleck 2 Medical EX	Physician: To the best of maminer: On the basis of exa	imination and/or inv	estigation in my oninion	death accurred a	t the time date and	solven and division to	11.	(1)
4	To the comple		only one) 3 L Certifying N 29b. Signature and title of certifier	Nurse Practioner: To the b	est or my knowleage	e, death occurred at the	time, date and plac	ce, and due to the ca	ause(s) and manne d. Date signed (N	er as state	d.
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(1,		503	ho completed cause of dea	ith (Item 23a) (Type LEET		GE, MD	21613.	JEEVA	m Ex	RABOLU MID
	State Registra	_	31. Date filed (Month, Day, Year) NOV 162	010 32/Registrar	s Signature	ach	, , ,				

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygien for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 8 2010 Carrie Johns 10:10AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Heritage Harbour Health & Rehab Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Marry) Land 8 Date of Birth Funeral 1 M 2 K F Days A(Mogth, 991 Year 916 214-44-6234 94 Yrs. Director Usual Residence of Decedent 10h County or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2042 Parker Dr. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 9 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 1 Yes 2X No Specify: "natural", Specify: 3 X Widowed 4 ☐ Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 9th Domestic None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 1 and 2 should be fill the straight and Mental tem 27 is marked ပ္ Norman Spriggs Daisy Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $21\overline{144}$ 19a. Informant's Name/Relationship (Type, Print) Daisy Dennis(Daughter) 8238 Riviera Dr. P.O. Box 373 Severn, 20a. Method of Disposition 20b. PIRespisation Mame of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Memorial Park 11-12-10 Annapolis, Md. 4 Donation 5 Other (Specify) Mmame Rasse of Pacility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Examine onsequence of): Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Day Pregnant at time of death Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ပ 1 Inpatient 2 I ER/Outpatient 3 I DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ce D38958 Name and address of person who completed cause of death (Item 23a) (Type, Print) MD un State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

		For		of Marylan						•		e Legibi e e	•	
	•	For State Registrar				tificate				,	Reg. N	2010	385	54
Physicia	m/	1. Decedent's Name (First, Mid-	dle, Last)							2. Date of De Month		ay Year	3. Time of	
Medic		Alice Mae JO								Nov.	26	2010) рм
Examin	er	4a. Facility Name (if not instituti				4b. City, To			f Death		4	c. County of Dea		
Funeral		Ravenwood Ass 5. Social Security Number	sisted Liv 6. Sex	1ng 7. Age (In yrs. Ia	ast birthday)	If Under 1		If Under 2		8. Date of Bir		Washin g. Bii	thplace (State o	r Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 🔀 Burial 2 🗀 Crematic			Place of Dispo emetery, cren	sition (Name natory or othe	of er place)		D	ate	20c. l	_ocation - City or	Town, State	
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To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the to the funeral filled in by the funeral director, page 2 should be detached for use as the tops of the funeral director.	Physician/Med	IF FEMALE:	23c If yes ou	tcome of pregna	nev									
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Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician/ Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

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			For State			State o	f Ma	ryland	-				and N	/lental	Hygie	ne ()	10	38556
			Registrar	(m	(4)				Cer	tificate	e of L	eath			Reg.	No.		
в	Physicia	ın/	1. Decedent's Name		le, Last)	D.		10	HNSON					2. Date of Month	h	Day	Year	3. Time of Death
	Media	al	4a. Facility Name (if		n dive str		her)	30	IIII	4h City	Town or	Location	of Death	NOVE	MBER		2010 ty of Deat	11:29 A
	Examin	er									NTON		I OI Death				-	EORGE'S
2	Funeral	8	SOUTHER 5. Social Security N		6. Sex			In yrs. las	t birthday)	If Under	r 1 Year	If Unde	r 24 Hrs.	8. Date	of Birth		9. Birt	hplace (State or Foreign
	Director		579-74-1		1 🗆	M 2 X) F	83	3	Yrs.	Months	Days	Hours	Min.	FEB	28 19	<u> 27 </u>	ALA	BAMA
1	d now	ایا	Usual Residence of 10a. State	Decedent 10b. County	/			10c. Citv.	Town or Loc	cation								10d. Inside City Limits
	arylan a-f st fied a	发	MD			EORGE '	- 1		ESTVI									1 X Yes 2 □ No
	or 28		10e. Street and Nur	nber	-					10f. Zip	Code				10g.	Citizen of	f What Co	untry?
	with t	Funeral Director	1904 NAI	PIER D	RIVE					20	747				US	SA		
	tems er mu	듄	11. Marital Status			2. Was Dece Armed Fo		er in U.S.	13. V	_		spanic O	rigin? (Spe	ecify Yes o	r No-			rican Indian,
36	fter d ", or i amin		1 Never Marr			1 Yes If Yes, Giv	2 X N	0		Yes				Tiloan, cio	•)	Specif	ack, White	e, etc. BLACK
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed by	3 😿 Widowed			Year or Da											<i>,</i> .	
15-	72 hc n "na Aedic	힐		15. Decede	est grade	completed)			16a. Deced (Give I	rind of wor O NOT use	rk done d	unng mo	st of work	ing	166	, Kind of	Business I	ndustry
212	within giene. er than	ខ	Elementary/Sec	onday (0-12) :h		College (1	-4 or 5+)			EWIFE						PRIV	ATE	
	filed valued valued vent,	Be	17. Father's Name (Last)							18. Motl	her's Nam	e (First, Mi	ddle, Maid	en <i>Surn</i> ar	ne)	
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Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Na						19b. Mailin									Code) 20747
	and 2 lealth sm 27 ther t		CLAUDIA 20a. Method of Disp		OK /	Daugn	ter	OOL DIA	ce of Dispo			; VKT A U						
Baltimore,	ge 1 at of h		1 Burial 2	☐ Cremation		emoval from	State	cen	netery, c re n	natory or o	ther place	e)		Date				Town, State
Iţin	urtmen artmen ortani injury		4 Donation 21. Signature of Tu					HAK	MONY			e of Facil		2/201 R				ARYLAND L HOME, INC.
Ba	permit. Page 1 and 2 si Department of Health a Important: If item 27 i any injury or other tra		A	AND	LICCHISCO													AND 20785
			23a. Part 1. Enter t					he death.										Approximate
-	Physician/		shock, or hea Immediate Cause (Final	only one	cause on ea	Ch line.	r M	WINGS -	Mha	de	In	Fare	hon				Interval Between Onset and Death
	Medical	H	disease or condition resulting in death)	ori	a.	Due to	or as a	conseque	nge of):	1		1 , (4	1. L	. `				
A. S.	Examiner		Sequentially list co	nditions	b.	er	hin) Sile	no tro	6	mn	any	and	my D	sens	L		
	п #	l Examiner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate rlying	l	Due to	or as a o	conseque	nce of):									
	executed an and rial-transit	xan	Cause (Disease or that initiated event resulting in death)	S	С.	Due to	or as a	conseque	nce of):									
			rooming in doubly		L.		`	·	,									
68760	cate by phys	edic			d.													
89	certifi nding use a	<u> N</u>	IF FEMALE: 23b. Was decedent	pregnant	23	c. If yes, out] Estable r	prognana	.,				23d. D	ate of del	ivery
Вох	leath e atte d for	icia	in the past 12 a	moptris? ☑ No		4 Preg	nant at t		death 3 L ath 5 □	Other (sp		y 			_	N	lonth	Day Year
P.O. E	v requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Completed by Physician/Medica	9 Unknown											1				
9.	s thai gned be de	ğ	Part II. Other signif		^	inbuting to a			ling in the U	- Len	cause giv	en in Par	t I.			2 PNo		the cause of death? obably 4 Unknown
rds	een s een s ould	ted	wid Joyc					Will	rc (ur		1	0113	<u> </u>					
000	law ru hasb e 2 st	lg													Was an autopsy performed		prior to o death?	opsy findings available ompletion of cause of
Re	: The cate ; pag	S												1 🗆	Yes 2 ₩	No	1 Yes	2 12 No
ital	sician certif rector	To Be	25. Was case referred exampler? 1 Yes 2		_	spital:					Othe	rr.		k only one)		a 🗆 a		
ž V	Phys rthis eraldi	<u>ا ۲</u>	27. Manner of Deatl			28a. Date	of injury	2	R/Outpatien 8b. Time of		8c. Injury	at		_	Residence ribe how in			<u> </u>
n c	nding ath. : Afte e fune	cat	1 ☑ Natural 2 ☐ Accident	5 Pendi	ing igation	(Mon	th, Day,	Year)	injury	М	work'	? Yes 2[□No					
Division of Vital Records,	Atter	if	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	not be	28e. Place	of Injury	/ - At hom (Specify)	e, farm, stre	et, factory	, office				ion (Street r Town, St		ber or Rui	al Route Number,
Ο̈́	italor irs aft al Dir ed in	<u>رة</u>																
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical Certificate:	29a. Certifier 1 (Check 2	Certifyin Medical	Examine	r: On the bas	is of exa	mination a	and/or invest	igation, in	my opinio	n, death o	occurred a	t the time, o	date and pla	ace, and d	ue to the o	ause(s) and manner stated
	the lithin 2 the l		only one) 3 29b. Signature and	Certifyin	g Nurse	Practioner:	To the be	est of my k	nowledge, o	eath occur	rred at the	time, dat	te and plac	e, and due	to the cau	se(s) and r	nanner as	stated. , Day, Year)
	5 ≥ 5 8		29D. Signature and	Mm	~		W	A)			005				2.1-	N/		2010
			30. Name and addre	ess of person	who con	noleted caus	e of dea	th (Item 2	3a) (Type, P	rint)				-				-010
12	5		RICHARD	PALME		ND 13	28	south	nem (rven	ne. S	2 3	mte	310 1	anh	napos	7 00	20032
	Sta	te	31. Date filed (Mont.	h, Day Year	h	32. R	egistar'	s Sio	K							9		
	Registra	ar	NIIV	J LUIV	LIV			• /										

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Frank J. Komenda 12:02 P M 2010 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min Washington, Vrs Director 578-44-9903 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Anne Arundel Maryland Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 831 Coxswain Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent Even III 0.3.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give
Year or Dates. 1954—57 1 ☐ Never Married 2 🗓 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 🗆 Widowed 4 🗆 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Legislator State of Maryland vears Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Theresa Venuto Joseph A. Komenda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 831 Coxswain Way, Annapolis, Maryland 21401 Carole A. Komenda/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 11/19/10 Crownsville, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fune Service Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes 2 No. 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 Tes 25. Was case referred to predical Be 26. Place of Death (Check only one) Other: 2 1 1 Tyes ပ္ 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No iniury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Praction r. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Ridgely Avenue, Annapolis, MD 21401 Ira Weinstein, M.D. 31. Date filed (Month, Day, Year) State 7 2010 NOV 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per INF G910 12/15/10 Jh State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11/10/2010 Physician/ Francis Bernard Kennedy, JR. 0705 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death <u>Anne Arundel Medical Center</u> Arundel <u>Annapolis</u> If Under 1 Year Months Days **Funeral** Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign XXM 2 D F Hours 1272671924 Country) **Director** 426-34-5003 85 MS Usual Residence of Decedent 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director San Diego Encinitas 1 Yes 2XXNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 214 Peckham Place 92024 USA 12. Was Decedent Ever in U.S. Armed Forces? ★★★ Yes 2 □ No WW If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married WWII Baltimore, Maryland 21215-0036 1 Yes & No Specify Completed 3XXWidowed 4 ☐ Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 0wner Shipping Company injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis B. Kennedy, SR Clough O. Stalling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Kennedy Son 3416 Cohassett Ave. Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial ※X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 11/11/2010 | Glen Burnie, MD 22. Name and Address of FacilityHardesty Funeral Home, P.A. Signature of Funeral Service Licensee any A 7 Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Directo (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No o 5 Other (specify) Month Pregnant at time of death signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy perform ☐ Yes 1 Yes 2 🗌 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Accident 1 🗌 Yes 2 🗌 No 24 hours after death Prineral Director: Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 within 2 To the I only one 29b. Signat 29c. License numbe 29d. Date sign Day, Year) 2010 no completed cause of death (Item 23a) (Type, Prin ame and a

State

Registrar

30

onth, Day, Year)

NOV 1 2 201

32. Registrar's Signature

Elizabeth W. Kraus

			For State Registrar	State of Marylan	_	artment of rtificate of				giene Reg. No. 2	010	29	550
	Physicia		1. Decedent's Name (First, Middle, Last) Elizabeth W.	Kraus					2. Date of De Month	ath Day	Year 2010	3. Time	of Death
The state of the s	/Medic Examin			street and number)		4b. City, Town,	255	of Death	ne	4c. Cou	inty of Death	rse	+
	Funeral Director		219-32-0104	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bir (Month, Da 08/10/	ay, Year)	Coui	place (State otry) yland	or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomic		y, Town or Lo Salisb			-			1	0d. Inside	City Limits
,	3a or 28s	al Director	10e. Street and Number 1101 S. Schumake	er Drive		10f. Zip Code 218	304			10g. Citizen	of What Cour A	ntry?	
9800	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Madeal Evanitar must be notified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1		Was Decedent of If Yes, specify Cul 1 □Yes 2 🔏 No	ban, Mexica	n, Puerto F	cify Yes or No Rican, etc.)		Race - Americ Black, White, ecify: Wh		
Baltimore, Maryland 21215-0036	d within 72 h giene. rr than "natu rre Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during mos	st of workin	g		th car	,	
yland	e d d	To Be C	17. Father's Name (First, Middle, Last) Charles Dorsey War	field Jr.					(First, Middle eynold		name)		
Mar	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Ty Ann Wells/daughte			ng Address <i>(Str</i> ee 2 Cherry						Code)	
nore,	bages 1 all ent of Heat It: If Item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	20b. F	cemetery, crer	sition (Name of natory or other pla Cremato			ate /2010		on - City or To sbury,		
Balti	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Licens			Name and Add OITOWay OI Snow			·				tion
100	Physician		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that caused the deat ne cause on each line.	h. Do not ent	er the mode of dy		s cardiac o	r respiratory a	arrest,		Approxim Interval B Onset an	ate etween d Death
d	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	CO	P 1)						
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq									
8760,	icate be executed physician and s the burial-transit	dical	resulting in dedut) East	Due to (or as a conseq	uence orj:								
P.O. Box 6	ath certil attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3	⊒Ectopic pregnar ⊒Other (specify)	ncy			23d.	Date of delive	ery Day	Year
ds, P.	uires that n signed bi Id be deta		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause g	jiven in Part	1.		tobacco use o	contribute to to	_	f death?] Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed by							24a. Was auto perfo 1 □ Yes	psy ormed?	4b. Were auto prior to co death? 1 □ Yes	mpletion o	gs available f cause of
Vit	ysician is certif director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	dhaw d		(Check only one 5 ☐ Res		Other (Speci	fy)	
ion o	nding Ph tth. :: After th e funeral	ation: T	27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	l Wo		2	28d. Describe				
Divis	- e e	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, office)	2	28f. Location (City or To	(Street and N wn, State)	umber or Rur	al Route N	umber,
	To the Hospital of within 24 hours af To the Funeral D Completely filled in	Medical		rsician: To the best of my kno iner: On the basis of examinated and manner stated.									e(s)
	To the vithin To the	Me	29b. Signature and title of certifier				nse number				igned (Month)
)	5MY		30. Name and address of person who co	ompleted cause of death (Itel	n 23a) (Type,	Print)	1074 1. She	w	SAUSI	بدن	mg 21	₹ NY	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		arke							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 20b per FH G910 12/17/10 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Day 10 2010 Physician/ Ida R. Kosco 9:22A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Wicomico Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🏞 F 277-22-3837 01172371924 Pennsylvania 86 Director Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Maryland Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7504 Jones Hastings Road 21849 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: white 3 X Widowed 4 ☐ Divorced Specify: Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elesta Hook Harry Emerick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Alden Ave., delran, NJ 08075 Mary Medd/sister injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 11/18/2010 Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, MPW disease or condition Medical resulting in death) Due to (or as a consumuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops, performed? After this certificate Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific 25. Was case referred to medical **Division of Vital** the funeral director, Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d, Date signed (Month, Day, Year) 10 3m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thimmarayappa M.D. 910 Easternshore Dr Salisbury MD 21804 Mahesha 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Shellia Faye King 17:42 PM 11/1472010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 🗆 M 2 🔀 F Days Hours 0170571961 Yrs. Director 426-35-9084 Usual Residence of Decedent or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** Prince George's Clinton 1 X Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a 6206 Armor Dr. AZU 20735 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Supervisor Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Smith Joe Pickens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6206 Armor Dr., Clinton, MD 20735 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Orbett King / husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 17/52/5070 Jerusalem Church Cemi Bay Springs, MS 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility

500 Allentown Rd., Camp Springs, Services MD 20748 21. Signatu Funeral Service 22. Name and Address of Facility 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner 51 Selesi Sequentially list conditions, Physician/Medical Examiner rany, sading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Duc to for as a sunsequence of sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CArcinoma 1 Yes 2 1 No 3 Probably 4 Unknown End Stone 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0105

Registrar
DHMH 17 Rev 7/2009

State

Suite

200

Pale

20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signat

Jennifer Marie Kain

10-09200 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month **Medical Examiner** Jennifer Marie Kain 1857 hrs November 30, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 70 North East Isles Drive North East Cecil If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MWDD/YYYY) | 9. Birthplace (State or Foreign I entrisy L Vania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 1 M 2 X F Country) 210-66-2890 06/14/1980 30 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Pennsylvania Delaware Media 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the May Department of Health and Mental Hygiene. 喜 261 Lenni Road 19063 United States Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes 1 Yes 2 No specify: 3 Widowed 4 X Divorced Specify: White ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 11 Bookkeeper Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surriame) t: If item 27 is marked other traumatic event, Be Sherry DePaul Barry L. Kain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barry L. Kain/Father 261 Lenni Road, Media, PA 19063 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State December Baltimore, 1 Burial 2 X Cremation 3 Removal from State 3, 2010 Pagano Crematory Garnet Valley, PA Donation 5 Other Specify: Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Alprazolam and Oxycodone Intoxication Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and tran Physician/Medical AMENDED 23a,27,28a-f per me g912 2-2-11 vt X UNPENDED attending physician or use as the burial -Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown Unknown of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? ER/Outpatient 3 DOA Other; Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ٩ 1 V Yes No 28a. Date of Injury (Month, Day Year 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: __ Natural Pending death. 1 Yes 2 X No the fd 11-30-10 fd 6:40pm unknown Accident 28f. Location (Street and Number or Bural Route Number, City or Town, State) 70 North East Isles North East, Cecil Co., Md. 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire 6 X Could not be 3 Suicide determined residence (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number no O.C.M.E December 1, 2010 30. Name and address of person who completed cause of death (Item 23a) Lina Li. MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (MD) Pay (Sear) State

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Ellen A. Loller 2010 0 Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death 0 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗌 M 2 🔀 F 06 10 1919 Months Hours Maryland 213-18-5685 Director Usual Residence of Decedent or 28a-f show notified at with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🖁 Yes 2 🗌 No Wicomico Willards Maryland 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? r items 23a or ner must be r Funeral 7295 Canal St. 21874 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important if item 27 is marked others any injury or others. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Domestic Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Florance Nicholson Harry Christopher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris Smullen|Daughter 8037 Downs Rd., Newark, MD 21841 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other concentry 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10 22 2010 Chestertown, Maryland Signature of Puneral Service Licens 22. Name and Address of Facility, Home P.A. 501 Snow Hill Rd., Salisbury, Md 21804 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ALZHIBMAN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner BOWILL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tyes ဂ္ 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brep 733 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

backs

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Amended item#2,11.29.10,SLU,Certificate of DeathWCHD 1. Decedent's Name (First, Middle, Last) 2. Date of DeathNov. 15, 2010 Physician/ Naomi L. Lowe 2010′ 5:30 p^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula Regional Medical Cntr. Salisbury Wicomico 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) Director 214-28-2091 8. Maryland Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Worcester Snow Hill 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 430 West Market Street 21863 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Purchasing Manager lFood 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert E. Hudson Ella W. Nock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debbie Collins/ Daughter 7807 Downs Road, Newark, MD 21841 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/19/2010 Evergreen Cemetery Berlin, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Holloway Puneral Home, Professional Association 501 Snow Hill Road, Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death CARDIOVASCULAR Physician/ ATHEROSCLEROTIC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is the last of the cause of the cau Examine Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Year be detached 1 ☐ Yes 2 ₺ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 \square Pending ☐ Accident ☐ Suicide Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 62172 11/19/2010 MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JA

DHMH 17 Rev 7/2009

Registrar

acke

SATYAL, MD

23

32. Registrar's Signature

31. Date filed (Month, Day, Year)

1604 MARKET ST. POCOMOKE CITY ND 21851

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November 19, 2010 Physician/ Love Charles William 3:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Clinton Southern Maryland Hospital Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Months Days NOV. 28 1 🔀 M 2 🗆 F 249-86-8443 60 South Carolina Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 ehror any injury or other traumatin avont. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director District Heights Prince George's MD 1 X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 5915 Nassau Street 20747 U.S. 12. Was Decedent Ever in U.S.
Armed Forces?
1 K Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
African-American Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: 3 🗌 Widowed 4 🗎 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dennis Love Novella Lockhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Love-Spouse 5915 Nassau Street, District Heights, MD 20747 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, MD 12-1-10 Md Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 20018 21. Signature of Funeral Service Lipenses 22. Name and Address of Facility Bornette & Assoc. Funeral Home 2504 28th St., N.E., WDC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death MYOCARDIAL Physician disease or condition Medical resulting in death) Examiner ACUTS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be retrached for the period to the funeral director. that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes ≥ L g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SERURA DUSINGR 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Division of Vital

Registrar

29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9628 MARLBORD

31. Date filed (Month, Day, Year) NOV 2 3 2010

Rous 80

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D48158

4 PPER MARLBORD MD

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 9 2 0 1 0 Vanessa L. McHenry 9:18 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 814 Chesapeake Avenue Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Feb 7 1952 Director 217-62-9645 Maryland 58 Usual Residence of Decedent items 23a or 28a-f shov her must be notified at 10a State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 814 Chesapeake Avenue 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ral", or iten l'Examiner 14. Race - American Indian Black, White, etc. 1X Never Married 2 ☐ Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 Widowed 4 Divorced Specify: **Black** Year or Dates other traumatic event, the Me Ical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) 4yrs Asset Manager Officer State of Maryland Be it. Page 1 and 2 should be filed rtment of Health and Mental Hy rtant: If item 27 is marked otf 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Reginald McHenry Elaine Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheree Hastey(Daughter) 814 Chesapeake Avenue Annapolis, Md. 21403 20a. Method of Disposition 20b. Hacelof Disposition garge of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 11-15-10 Annapolis, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Miname Races Cof RecilitSons Mortuary, P.A. Ham 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 0191 disease or condition 100VS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or ilinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) Day Year Pregnant at time of death 2 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 X No certificate 1 🗆 Yes 2 XNo 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 Yes 2 No Hospital. Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, After this 28a. Date of injury (Month, Day, Year) Manner of De 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 Yes 2 No neral Director: A Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number DS2-73 C weing, MI canine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 ND 2003 Medical parking #210, Ameple, MD 21401 werner,

Registrar
DHMH 17 Rev 7/2009

State

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(11)	o ixuici	-	For State Registrar	State of Marylar		tificate of L			eg. No.	0 38567					
			1. Decedent's Name (First, Middle, Last)	·				2. Date of Death	1	3. Time of Death					
	Physicia Medic		James & Mi	organ				Novembe	er 10, 2	2010 5:30 PM					
· Prof	Examir		4a. Facility Name (if not institution, give sti Anne Arundel Medí				r Location of Death apolis		4c. County of Anne	of Death Arundel					
	Funeral Director			M 2 □ F 7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 111/02/57 ^a 1/5	940	9. Birthplace (State or Foreign CountrMaryland					
	faryland Ba-f show tified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arun	ide1	y, Town or Loc	cation Anna	apolis			10d. Inside City Limits 1 ☐ Yes 2X☐ No					
	th with the Maryland ns 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 1192 Hampton Road			10f. Zip Code	21409	11	0g. Citizen of W	hat Country?					
900	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It if item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Married 2 🔀 Married : 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.s Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 61-6		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- American Indian, k, White, etc. White					
1215-(hin 72 ho ne. than "nat • Medic;	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give A	O NOT use retired)	during most of worki	ng	16b. Kind of Bus						
Maryland 21215-0036	be filed wit ental Hygie ked other c event, th	To Be C	9 17. Father's Name (First, Middle, Last) Jesse Morgan		l Mari	псатпапсе	Supervis 18. Mother's Name Mary I		aiden Surname)						
	12 should alth and Me 127 is mark		19a. Informant's Name/Relationship (Type Peggy Morgan - V	, Print) Vife	19b. Mailin	g Address (Street 2 Hamptor	and Number or Rura n Rd, Anna	al Route Number, Capolis, N	ity or Jown, St.	ate, Zip Code) 21409					
Baltimore,	permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crem	sition (Name of natory or other place Cemetery	ce)			City or Town, State					
Balti	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee Myslin i, Wol	Beck		Name and Addres			•	uneral Home s, MD 21401					
d	Priysiciani Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):												
-	Examiner ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):										
09289	ath certificate be executed attending physician and for use as the burial-transit	edical E	resulting in death) Last	Due to (or as a consequ	ence of):										
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c 9 Unknown	l death 3 🗆	Ectopic pregnanc	су		23d. Date Mont	e of delivery th Day Year					
ds, P.O.	requires that the de been signed by the s should be detached	ed by P	Part II. Other significant conditions cont	ributing to death but not res	ulting in the ur	nderlying cause giv	ven in Part I.			oute to the cause of death? 3 Probably 4 Monknown					
Records,	The law recate has being page 2 sho	Completed by						24a. Was an autopsy perform	pr ed?/ de	ere autopsy findings available ior to completion of cause of eath?					
tal	cian; ertific ector,		25. Was case referred to medical examiner?	itl			ace of Death (Check	only one)							
Ž	Physic this c al dire	욘	1 LJ Yes 2 LJNo	spital:			4 U Nursing Ho	me 5 🗆 Residen							
0 0	ding F h. After funer	ate	27. Manne f Death 1 ≝ atural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun work	?	28d. Describe how	injury occurred	d					
Division of Vital	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre)		Yes 2 No	28f. Location (Stre City or Town,		or Rural Route Number,					
_	ne Hospit: n 24 hours ne Funera pleted fille	Medical	(Check 2 Medical Examine	ian: To the best of my knowler: On the basis of examination	and/or investi	gation, in my opinio	on, death occurred at	the time, date and	place, and due t	to the cause(s) and manner stated.					
	To the with To the com		29b. Signature and title of certifier	unter so	0	29c. License	number 214			(Month, Day, Year)					
_	5*6	. (3	30. Name and address of person who com	pleted cause of death (Item	23a) (Type, Pr	RIAL	y Ave	, Anr	1401/13,	γ_{0}					
8	Stat Registra		NOV 16 2010	32. Registrar's Signat	ure	<i>Q</i> ,	f		1						

that the death certificate be executed Box 68760 P.O. 1 Hospital or Attending Physician: The law requires Records, Division of Vital

Maryland 21215-0036

Baltimore,

To the Hosp within 24 ho To the Fune completed fi 841NZ

State Registrar 29a. Certifier

only one

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29b. Signature and title of certifier

1cm ne

31. Date filed (Mont **1** 6 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

34 uvensville icibaum WO 32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 20, 2010 **Physician** 7:28 A. M Rosemary Marselas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Gladys Spellman Specialty Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 08/20/1949 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 ☐ M 2 👿 F Ohio Director 302-50-1182 Usual Residence of Decedent worle 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Calvert Chesapeake Beach 289-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō U.S.A. 3693 Brookside Drive or iteme 23a 20732 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or item any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 ☐ Never Married 2 📉 Married Baltimore, Maryland 21215-0036 à 1 ☐ Yes 2 1 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) registered nurse health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stanley McCabe Billie Steide1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley E. Marselas, Jr., husband 3693 Brookside Dr., Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify Metropolitan Crematory 11/21/2010 Alexandria, VA Signature of Funeral Service Licen 22. Name and Address of Facility Rausch Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. As Tokuscustum of Cambridge (Final disease) 8325 Mt. Harmony Lane, Owings, MD Approximate Interval Between Onset and Death Physician Jess no /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): been signed by the attending physicien a should be detached for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No HynoThy wid 1 Yes i or Attending Physician: after death. Director: After this certifica 25. Wa case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo 1 ☑ Inpatient 2 ☐ ER/Outpatient Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel or within 24 hours aft To the Funerel Di

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

Medical

DHMH 17 Rev 1/2001

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

20185

29d. Date signed (Month, Day, Year)

reasting at that suille MD 20181

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ **AGNES** ELIZABETH MILLER 2010 10:21 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Williamsport Retirement Home Williamsport Washington County 8. Date of Birth (Month, Day, Feb. 27 . Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Min. 1 M 2 XF Hours 236-54-3001 94 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Co. Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18124 Woodside Drive 21740 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 √ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Switchboard Operator Medical Supply Co. is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Petry Edna Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Y. Michaleski/Daughter 18124 Woodside Drive, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Rose Hill Cemetery Nov. 27,2010 Department of Important: If it 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 23a. Part 1. Ent., the disease, ir complication, that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. N. Hagerstown, MD Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ dvanced disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of resulting in death) Last Physician/Medical attending pl for use as t IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death ed by the a detached f 1 Yes 2 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? certificate has page 2 No 1 Yes Physician; 25. Was case referred to medical examiner? Be funeral director, 26. Place of Death (Check only one) Hospital Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural
Accident
Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: Aftered filled in by the fur Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 2- Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

(SH-3 State

Box 68760

Records, P.O.

Division of Vital

29b. Signat

Month, Day, Year)

580

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician 9:18 PM rances 22 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Baltimore Mercy Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 🕱 F Days Hours 66 May 5 1944 Director Maryland 217-42-7565 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c City Town or Location or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or items 23s 21740 Funeral 18034 Putter Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "naturel", or then eny injury or other treumatic event, the Medical Exempter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) Elementary/Secondary (0-12) College (1-4or5+) Board of Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Martha Jane Bartles Francis Sylvester Hose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18034 Putter Drive, Hagerstown, Md. 21740 Larry K. Moats, Sr. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 11/27/10 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland Broadfording Ch. Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bowel Ischemic **Physician** 48405 disease or condition resulting in death) /Medical Due to (or as a consequence of): empartment Syndrone Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit been signed by the attending physicien end should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy perform 2 No 1 ☐ Yes or Attending Physicien: director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Hospital: 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA neret Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation death. 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of US CUSTA 30\ST PACC THAORE, 54-16

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 5 & State of Maryland / Department of Health and Mental Hygiene State RegistrarItem 8 WCHD/SH 11/30/10 per Exertificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nauthonba Physician/ 2010 Julia Alma MILLER Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Washington County Hospital Washington Hagerst<u>own</u> 8. Date of Birth 8/24/1916 Birthplace (State or Foreign (Month, Day, Geat) West Virginia 7. Age (In yrs. last birthdav) If Under 24 Hrs. 6. Sex 1 M 2 X F If Under 1 Year **Funeral** Months Days Hours Min. Yrs Director 94 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f sho adical Examiner must be notified at Director 1 Tyes 2 X No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2011 Starlight Lane, Apt. 1-A 21740 USA and 2 should be filed within 72 hours after death v Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced and Mental Hygiene.

is marked other than "natur raumatic event, the Medical." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School System Teacher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Alma Miller Jeff Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Just Page 1 an.
Department of Hea.
Important: If item 27 any injury or otherate. 27 New Jersev 07940 248 Plymouth Court, Madison, Carlotta M. Budd - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/27/10 Hagerstown, Maryland 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md 21740 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 clay disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be 68760 attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached 9 Unknown P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed | 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No the Hospital or Attending Physician: The law I page 2 No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Funeral Director; After Natural Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 h To the Fur (Check 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 28365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Heigenstonn 368 19P State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 18, 2010 ARTHERRINE ELDRIDGE MINNIEFIELD 2:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES RESIDENCE. 9703 QUIET BROOK LANE CLINTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1944 ALABAMA 1 🗆 M 2 ី F Days Months Hours Min. MARCH 28. Director 423-56-7426 66 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No PRINCE GEORGES CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9703 QUIET BROOK LANE 20735 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 10TH GRADE College (1-4 or 5+) NURSING ASSISTANT HEALTH CARE and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve HOSEY MALONE ARTHERRINE ELDRIDGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD MINNIEFIELD/HUSBAND 9703 QUIET BROOK LANE, CLINTON, MARYLAND 20735 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State BRINSFIELD-ECHOLS CREMATORY NOV. 23, 2010 CHARLOTTE HALL, MD 4 ☐ Donation 5 ☐ Other (Specify) Spature of Funeral Service Doensee THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 MADIA C. THORNTON JOHNSON MOO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed use as the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 to 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No 1 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 P.O. or Attending Physician: The law requires t Records, Division of Vital 24 hours after death. Funeral Director: A filled in by the Hospital сопріете To the within 2

Maryland 21215-0036

Baltimore,

MR 6 State

Registrar

Medical

29a. Certifier

IVAN ZAMA, M.D.

29b. Signature and title of certific

20070102

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

9-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9200 BASIL COURT, SUITE 200, LARGO, MARYLAND 20774

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Example: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

32. Registrar's Signature 31. Date filed (Month. 2 2 2010 Keneur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05 John E. Marshall Medical 4b. City, Town, or Location of Death 4c, County of Death Facility Name (if not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Dec 27, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Hours 155-26-2671 Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at Director MD Wicomico Fruitland 1 X Yes 2 ☐ No 10e Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 202 Twigg Court 21826 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 XYes 2 No If Yes, Give A Year or Dates. 3altimore, Maryland 21215-0036 African-1 Tes 2 No Specify: Completed 3 Widowed 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) City of College (1-4 or 5+) Elementary/Seconday (0-12) Chief of Police Lakewood. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George C. Marshall Mabel C. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. John Kennedy/friend 212 Hollow Mist Dr., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta Greenwood Cemetery 10/23/2010 Lakewood, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licens 2 Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd.,Salisbury,MD 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ CARDIOMYOPATH disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed and tran Due to (or as a consequence of): attending physician at for use as the burial. Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2/ No 3 Probably 4 Unknown Division of Vital Records, 1 Nes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? within 24 hours a er det th.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 1 No 1 Yes To the Hospital or Attending Physician: within 24 hours a ler death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 힏 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 | 3 | only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 0 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 80 21807 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State
Registrameno#4b PerPhys POT11_23_10cm

Mintrile. LaSt) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 77\7<u>₽</u>\507@ 12:42 PM Johnny J. Martino Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's -Brandywine Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Funeral Social Security Number 7. Age (In vrs. last birthday) Days 1 X M 2 🗆 F Hours 0170371936 Director 248-56-9327 74 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Brandywine Prince George's MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9304 Cheltenham Dr. S0P73 AZU Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Plumbina Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Carrie Akens Pinckney Irmy Martino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hattie M. Doctor / sister <u>9304 Cheltenham Dr., Brandywine, MD 20613</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 4 ☐ Donation 5 ☐ Other (Specify) 77/30/70 Cheltenham, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Strickland Funeral Services Allentown Rd., Camp Springs, MD 20748 6500 23a. P = 1. Enter the disease, or complications that cause 1 he death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a conseguence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but pot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical :tor: After this certific / the funeral director, 26. Place of Death (Check only one) 2 No Hospital: Other: 힏 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Natural
Control
Suicide
Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Nov Physician/ 2010 McDuffie 4:00 p M James Α. Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 6709 West Forest Road #101 Prince George's Landover 8. Date of Birth (Month, Day, Aug 14 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday, **Funeral** 1 ₹ M 2 □ F 1936 South Carolina 579-44-5567 Director 74 Usual Residence of Decedent er than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d, Inside City Limits 10c. City, Town or Location 10b. County Director Yes 2 No MD Landover Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral death with 6709 West Forest Road #101 20785 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married 72 hours after Completed by Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: d Mental Hygiene. marked other than "natural", 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Contractor Private Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be file of Health and Mental Hitem 27 is marked of Sadie Bossie McDuffie Geneva Dubose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cathy McDuffie/daughter 2908 Upland Avenue, Forestville, MD 20747 injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If ite any injury or ot 1 Burial 2X Cremation 3 Removal from State Riverdale Crematory Nov 18 2010 4 Donation 5 Other (Specify) Riverdale, MD 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 21 Signature of Fu eral Service Licensee 7474 Landover Road, Hyattsville, MD 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Complications of Diabetes disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate pause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 No g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed' 1 Yes 2 **X** No 26. Place of Death (Check only one) Be 25. Was case referred to medical filled in by the funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Μ death. Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Yea NOV 2 3 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day A_{M} Dorothy Ann Mitchell 2010 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 119 Parker Road Salisbury Wicomico Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min (Month, Day, Year) 6-26-1925 Maryland Director 218-16-6624 85 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 119 Parker Road 21804 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify White Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Power Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of Jy Auge 1 and 2 should be separtment of Health and Mental Important: If item 27 is refar yinjury or other nee. Howard Green Bernice Rebecca Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21801 Richard S. Mitchell, Jr. - Son 305A Union Avenue, Salisbury, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Wicomico Memorial Pk. 11-23-2010 Salisbury, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home Celle 705 E. Main Street. Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. No not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach lip. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2X No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending I hours after death. uneral Director: Aft ed filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation To the Hospital or Atter within 24 hours after des To the Funeral Director completed filled in by th Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and itle of certifier 29d. Date signed (Month. Day, Year)

Registrar DHMH 17 Rev 7/2009 . Name and address

31. Date filed (Month, Day,

WILL

^{Year)} 2010

2

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records.

of Vital

Division

processon who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

10-08649 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Allan Alexander Newsome State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Allen Alexander Newsome 1010 hrs Medical Examiner November 11, 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min Director DC 6/18/1938 72 1XXM 217-34-8857 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ī 1 Yes 2 X No 23a or 28a-f show notified at once. Annapolis Anne Arundel MD rnore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 21401 114 2nd Street Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, White, etc. 1 Never Married 2 Married Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes White 1963 3 Widowed Divorced Yes, Give Year 1959 -Yes 2X No specify: Specify ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HVAC Tech/ Owner Heating & AC 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Randolph Newsome UNK Costello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, MD 21401 114 2nd Street Wife Nancy Newsome 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State rtant: 11/16/2010 Annapolis, MD Hillcrest Memorial Donation 5 Other Specify 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funecal Service 78 Annapolis, MD 21401 12 Ridgely Ave. Approximate Interval Between Onset and 23a. Part I. Enter the disease, or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner nause: Enter Underfying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical attending physician a or use as the burial -UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown ō Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has page 2 s performed? ✓ Yes 2 No 2 No 1 🗸 Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other After this 1 V Yes 2 No 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d Describe how injury occurred Certification 1 V Natural 1 Yes 2 No Pending the 1 Director: Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined 24 hours a Funeral I (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical (Check only 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. November 12, 2010 Name and address of person who com ted cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. 31. Date filed (Month, Day, 32. Registrar's Signature State 16 2010

Registrar

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 9:15 Ам November Mary Elizabeth Pearl Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Jefferson 4426 Lander Road If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** oct. 25, Year 930 1 □ M 2 🖾 F Virginia 80 Director 227-34-0128 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Jefferson Maryland Frederick 1 Yes 2 X No 10g, Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral United States 21755 4426 Lander Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married should be filed within 72 hours after or and Mental Hygiene. ۾ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic eventone. 17. Father's Name (First, Middle, Last) မ Mary Elizabeth Kaywood Elijah M. McDavid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4426 Lander Road, Jefferson, MD 21755 Donald Pearl / Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition November 18 cametery, crematory or other place)
Resthaven
Memorial Gardens 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 2010 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Low all Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. MD 21701 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Priysician metastatic age no carcinomo disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis sted filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 You
9 Unknown Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 XNo Hospital Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination almost invosegation, and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar and title of certific

no

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sessertmo

32. Regist ar's Signature

29b. Signature

31. Date filed (Month, Day, Yes

To the

29c. License number

MD 056890

29d, Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death r 6 <u>2010</u> Physician/ 5:30 A M November Sarah J. Parrish Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Kris-Leigh Catered Living Severna Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 6. Sex Funeral 1 □ M 2**X** F Hours Seoth Pag Year 918 Marvland 212-28-7506 92 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c, City, Town or Location Director 1 ☐ Yes 2X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1974 Forest Dr 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Armed Force Black, White, etc. 2 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify Specify: Black. Completed 3 Widowed 4 XDivorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Receptionist **ECAC** Ô 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Carrie E. Nelson Howard H. Phelps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7932 Lowber Ave Philadelphia, Pa. 19150 Carol Ray(Daughter) Baltimore, 20b Place of Disposition Frame of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 11-13-10 Annapolis, Md. 4 Donation 5 Other (Specify) Mane Research MilitSons Mortuary, F.A. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 Harry 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospitallor Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -tran resulting in death) Last burial attending physician Physician/Medical Records, P.O. Box 68760 the ! IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 1 1 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an frer death. autopsy performed? Yes 2 page 2 1 🗌 Yes Division of Vital within 24 hours after death.

To the Funeral Pirector After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 1100 Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certificate: To 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 5 31. Date filed (Month, Day, Year) 32. State NOV 12 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2010 Physician/ 4:40 РΜ November Hazel Irene Pinkerton Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Solomons Solomons Nursing Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday Funeral Hours 1 □ M 2 🖾 F 1071771914 California 96 Director 224-50-2306 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 💆 No Prince Frederick Marvland Calvert 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20678 United States 880 Hilendale Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. White If Yes, Give Year or Dates Specify: 3 ₩ Widowed 4 □ Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) al Hygiene. I other than " College (1-4 or 5+) Elementary/Seconday (0-12) US Government traumatic event, the Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I မ Nellie Vaughan pe. George Spencer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 880 Hilendale Way, Prince Frederick, MD 20678 Margaret Rymer / Daughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 ₭ Burial 2 Cremation 3 Removal from State Arlington National Cemetery 01/07/2011 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILUNE Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a conseque of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation 3 Suiciae 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, details and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D52242 November 22, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

10

John Barth,

NOV

31. Date filed (Month, Day, Year)

III

2 2 2010

MD 110 Hospital Rd.

32. Registra s Signature

Suite 310, Prince Frederick, Maryland 20678

			PI	ease Type											gible.		
			for State Registrar	Stat	e of Ma	aryland	•	artment tificate			and M	1ental Hy	gien Reg. 1	-21	010	38	582
	Physicia	n/	1. Decedent's Name (First, Mi									2. Date of De Novemb	eath		- Year	3. Time	
Act,	Medic	al	John A 4a. Facility Name (if not institu	1fred	Prot	ıty		4b. City, To	up or	Location	of Dooth	Novemb			2010 ty of Death		.5 A.M
	Examin	er	Calvert Men		,	1				nce F		rick	ľ		Calve		
	Funeral		5. Social Security Number 220–32–6263	6. Sex	7. Age	(In yrs. last		If Under 1		If Under:		8. Date of Bir	rth		9. Birtl	nplace (State	or Foreign
	Director		Usual Residence of Decedent			87	Yrs.					Dec.	[5, [922	Mar	y land	
	land show dat	tor	10a. State 10b. Cou	nty		10c. City, T	own or Loc	ation					•			10d. Inside (City Limits
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36	after d ", or i kamin		1 Never Married 2 X	Married 1 X	d Forces? Yes 2 1 , Give	No		Yes, specify Yes 2			i, Puerto i	Hican, etc.)		Speci	ack, White	, etc.	
9	ours a	etec	3 Widowed 4 Divor	dent's Education	or Dates. 1	<u>.943-4</u>	6	ent's Usual C					166		whi		
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ary	hould and M is mar		19a. Informant's Name/Relation		<i>y</i>		19b. Mailin	g Address (S	treet ar			l Route Numbe					
	nd 2 s lealth m 27		Margaret G. I	routy, s	pouse	1				int R	load,	Hunti	ngto	own,	MD 2	0639	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Me Ical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremat		from State	cem	etery, crem	sition (Name on natory or other	r place			Date			•	Town, State	
Hin	nit. Pa artmel ortani injury		4 Donation 5 Other			Metr		tan Ci				23-10 sch Fu			ndria		
ñ	permit Depar Impor any in		> Willio	mR.	Tro	\						ne, Ow				736	
			23a. Part 1. Enter the disease shock, or heart failure. L	or complications t st only one cause o	hat caused on each line.				1.	, such as o	cardiac o	r respiratory a	rrest,			Approxima	etween
, <u>-</u>	Physician/ Medical	99	Immediate Cause (Final disease or condition resulting in death)	a	tout			readil	173						- 1	Onset and	Death
mart	Examiner		Due to (or as a consequence of): Sequentially list conditions, b.														
	- ±	iner	if any, leading to immediate cause. Enter Underlying	Due Due	e to (or as a	consequen	ce of):										
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68760	tificate ng phy	Med	IF FEMALE:														
Box 6	ath certificate be ex attending physician for use as the buria	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	1 🛄 1	Live Birth 2	of pregnancy 2 Fetal de time of deat	eath 3 🗌	Ectopic pred							ate of deli	very Day	Year
. B	the dea	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Unknown	time of deal		Other (speci	''9/								
P.O.	s that gned k	by	Part II. Other significant con	itions contributing	to death bu	it not resulting	ng in the u	derlying cau	se give	n in Part I	D.b.	23e. Did t				the cause of	
rds	equire	eted	Chronic plus Diabetes me	Acute Co	ngest	ve He	art	Ferilur	P. 1	70744	7011			2 No		obably 4	
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a R	an: Th tificate tor, pa	Φ	25. Was case referred to medi)		Crei			ce of Deat	h (Check	1 Yes	2 X	No	1 ∐ Yes	2 🗆 No	
Zit.	'hysici his cer il direc	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital:				t 3 🗆 DOA	Other	4 🗆 Nu	rsing Ho	me 5 🗆 Resi	dence	6 □ Ot	her (Specii	y)	
n of	ding P h. After t funera	Certificate:	27. Manner of Death 1 Natural 5 Per 2 Accident Investigation	ding (i	Date of injury Month, Day,	Year) 28	b. Time of injury	28c.	Injury: work?	at ′es 2□		28d. Describe	how inju	ury occu	rred		
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Ω	ital or ars afte ral Dir			D								City or Tov					
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the bur	Medical	(Check 2 Medic	ing Physician: To t al Examiner: On the ing Nurse Praction	e basis of ex	amination an	nd/or invest	gation, in my	opinion	, death oc	curred at	the time, date	and plac	ce, and d	lue to the ca	ause(s) and m	anner stated.
	To the within To the comp	2	29b. Signature and title of cert	fier				29c. Li	cense	number			29d. D	ate sign	ed (Month,	Day, Year)	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 15 2010 16:50 P.M Par Ker William Hlexander November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Westover Somerset Revells Neck Rd 29140 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**№** M 2□ F Yrs. 221-18-5347 January 11, 1933 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Westover Directo Somerset Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. Revells Neck 29140 21871 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Ness 2 No If Yes, Give Un know.∧ Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Wilson Freight Co. Truck Driver leth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Parker 2 Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dylan Parker - Son Botavia St, Apt 1, Drange, CA, 92868 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Ma Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Anthony E. Ward F.H. 11/22/10 Crematory of Delmarka 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hampden Ave. Princess Anne, md 21853 30639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic prostate /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse uence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cardiomyopath Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 this certificate 25. Was case referred to medical examiner?
1 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D70053 November 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 East Carroll Street, Salisbury, Mary and 21801

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

NOV 18 2010

pare

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ o vembe Q'44 am CARVELL POOLE Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death DOCTOR'S HOSPITAL PRINCE GEORGE'S LANHAM 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Days Hours Min. Months Director 579-50-7451 AUGUST 1937 WASHINGTON, DC Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number ò 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 900 BOOKER DRIVE 20743 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 2 No AIRFORCE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 12TH <u>PROGRAM ANALYST</u> GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ESCAR POOLE permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke any injury or other traumatic traumatic MATTIE BUTLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN J. POOLE/WIFE 900 BOOKER DRIVE CAPITOL HEIGHTS, MARYLAND 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 11/20/2010 SUITLAND, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2x No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 5 Pending ours after death. leral Director: Aft filled in by the fur 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) State Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			•	State Registrar			,	Cei	rtificate	of De	eath	on.car i i j	Reg. N	No.		88383
		Dhysisis	-/	1. Decedent's Name								2. Date of De		Day Voor		Time of Death
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		Examin	er			e street and number)					ocation of Dea	th		4c. County of Death		
				15 Social Security Number 1 6 Sey 17 Age (In use lest highder) 1 If Index 1 Year 1 If Index 24 Hrs 1 9 Data of Birth								Wicom	ICO			
		Funeral Director		5. Social Security N 221-20-6 Usual Residence of	832 1	Sex IM 2 □ F	ge (In yrs. I				Hours Min		rth ay, Ye <i>ar</i> 19	9. Bi	thplace puntry) De I a	(State or Foreign
	20	show	or	10a. State	10b. County		10c. Cit	y, Town or Lo	cation						10d. l	nside City Limits
	Many	28a-f	Funeral Director	DE	Susse	ex	1	Laurel							1	I ☐ Yes 2 🔼 No
	9	a or 2 be no		10e. Street and Nun	mber				10f. Zip Co	ode			10g. (Citizen of What C	ountry?	
	4	ns 23	nera	10141 Ch	erry Stre	eet			19	956				U.S.A.		
	400	r item		11. Marital Status		12. Was Decedent Armed Forces	>	S. 13.	Was Decedent f Yes, specify	of Hisp Cuban,	anic Origin? (S Mexican, Puer	Specify Yes or No- to Rican, etc.)	-	14. Race - Ame Black, Whit		dian,
	Maryland 21215-0036	pentitive rage is an 2 should be the while it is not a site of each will the way yand Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Marr 3 ☐ Widowed	ied 2 Married 4 XDivorced	1 Yes 2 2 If Yes, Give Year or Dates.	No		1 ☐ Yes 218					Specify:	whi	te
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Donald	Baltimore,	partm porta / inju	- 4	21. Signature of Fur			110		. Name and A	_				al Home	тула	2110
M (n	E E E E	V 1	Ciny	Show	t Vew	ell		l3 East	Gr	ove Str				1994	0
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	DIVISION OT VITAI KECOFUS, tal or Attending Physician; The law requires	er des ector by th	Certificate:	3 Suicide 4 Homicide	6 Could not b	28e. Place of In			eet, factory, of	fice		28f. Location (Street a	nd Number or Ru	ral Rout	e Number,
	ta o	rs aftr al Dir ed in			2	building, e	.c. (Specify)				City or Tov	vn, Stat	te)		
	iospi	t hou uner ed fill	Medical	29a. Certifier (Check 2	Certifying Phy	sician: To the best o	f my knowl	edge, death o	occured at the	time, da	ate and place,	and due to the ca	ause(s) a	and manner as sta	ated.	and manner stated
	the h	within 24 hours after death. To the Funeral Director: After this certificate I completed filled in by the funeral director, page		only one) 3	Gertifying Nur	se Practioner: To the	best of my	/ knowledge,	death occurred	at the tir	me, date and pl	ace, and due to th	ne cause	e(s) and manner as	stated.	
	٩	vit co		29b. Signature and	une of certifier					cense nu			29d. D	ate signed (Monti		'ear)
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	41	W		30. Name and addre		completed cause of	death (Item		1722	0	5 241 Ally 1	11111	11.1	11	7 0 -	
	(Stat	e	31. Date filed (Month	h, Day, Year)		ar's Signat		1/35	3/	11-7/	, ur	~	7 01	001	
		Registra		Λ	INV 20 21			a h	n. V. j							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 38586 Amend#23aPrt.1.PerPhys.PCC11-23-16@rtificate of Death Reg. No. 2. Date of Death Time of Death Physician/ ISON Medical 4a. Facility Name (if not institution, give street and numb Examiner 4b. City Town, or Location of Death 4c. Qounty of Death ash IN w Social Security Number last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Washington D(Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shor any injury or other traumatic event, the Medical Examiner must be notified at 10b. Town or Location 10d. Inside City Limits Funeral Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Obuntry? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Armed Forces White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Maryland 21215-0036 1 🗆 Yes 2 🕽 🛶 Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Callege (1-4 or 5+) Be 's Name (First, Middle, Mother's Name (First, Middle, Maiden Surname ည OINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ploster Washington MU Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State emolud 11-16-10 entage 4 Donation 5 Other (Specify) Sig ture 2 Name and Address of Facility Springs 140 20746 Wiseman Funerici 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. Pulmona disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and executed Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗆 Yes 2 🗌 No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, deam occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier rson who completed cause of death (Item 23a) (Type, Print) 30. Name and addres SITAH 2041 31. Date filed (Month, Day, Year) NOV 2 3 2010 State ack Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifica	ate of D	eath		f	Reg. No.		
Physic		Decedent's Name (First, Middle						2. Date of De Month	ath		3. Time of Death
Medical Exam	ine	Beeven	Barry Reib	er					Day Ye er 1, 2010	ar	1352 hrs
		4a. Facility Name (if not institution St. Joseph's Medical C				City, Town, or Loca	ation of Death		4c. County		
						owson			Baltimo		
Funeral Director		176-44-0328		n yrs. last birt) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birth Months Days Hours Min. Foreign					
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re, MD 2121 1 and 2 should be fi Health and Mental fitem 27 is marked		Sondra L. Wagan	nan	{	8695 S	heffield	Manor	Blvd.	Waynes	oro,	, PA 17268
10re, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatic		20a. Method of Disposition 1 X Burial 2 Cremation	3 Pernoval from State		f Disposition ry or other pl	(Name of cemeter ace)	у,	Date	20c. Location -	City or To	own, State
		4 Donation 5 Other Spe	-			emetery	12/6	/2010	Wayne	sbord	, PA
Baltimore, permit. Pages 1 as Department of Hee Important: If ite		21. Signature of Funeral Service L	icensee	-	22. Name	and Address of F	acility Gr	ove-Roy	ersov Fi	iners	1 Home Tr
@ 82 4 5		Claves	Bovers			. Broad	St. Wa	aynesbo	ro, PA	1726	11 Home, In
Physician		23a. Part I. Errer the disease, or c failure. List only one cause o	omplications that sused the	death. Do not	enter the mo	de of dying, such	as cardiac or	respiratory arr	est, shock, or hea	art	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease	a. Hemopericardium								Between Onset and Death
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Box 68 e death certif	Physiciar	1 Yes 2 No 9 Unkn		ordeath 5	Other (Specify)					
D. B. t the de by the ached f		Part II. Other significant condition		not resulting	in the underly	ring cause given i	n Part I.	23e. Did to	bacco use contrib	oute to the	cause of death?
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit	Completed							24a. Was a			osy findings available
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To the Ho within 24 } To the Fu	Sa	(Check only one) 1 Gertriying Physical Exami	siclan: To the best of my kno ner:On the basis of examinat	wledge, death ion and/or inv	occurred at estigation in	the time, date and my opinion, death	d place, and du occurred at t	ue to the cause	e(s) and manner a	is stated.	Queo(s)
To vitl	Medical	29b. Signature and title of certifier	and manner stated.			29c. License num					
		11/1	1/1/1		ľ	O.C.M.E.			29d. Date signed December 2		∪ay, rear)
	-	30. Name and address of person when the state of the stat	asself over	(ltam 00 :		J. O. WI. L.				, 2010	
		Melissa Brassell, MD	no completed cause of death Assistant Medical Exa	,	I11 Penn	Street, Baltim	ore. MD 21	1201			
St	ate	31. Date filed (Month Day Year)	32. Registrar's Sig				,				
Regist	_		Lord Stevens	for	park	Color					

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** DEC. 3, 2010 DONALD E. REPHANN 12:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 554 MARYLAND STREET ALLEGANY LAVALE, MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 2 M 2 □ F Months 89 MARYLAND Director 215-14-6435 OCT. 27, 1921 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director ALLEGANY MD LAVALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 554 MARYLAND STREET Funeral 21502 12. Was Decedent Ever in U.S.
Arged Forces?

1 ⊟Yes 2 □ No 1942
If Yes, Give
Year or Dates: 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🔀 No \$ Specify Specify. 3 XWidowed 4 ☐ Divorced WHITE 1946 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LITTON IND - CONTRACTOR WELDER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EARL REPHANN 2 DAISY (SHANNON) REPHANN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Heaith ar permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr. once. 27 VALERIE J. REPHANN DAUGHTER 554 MARYLAND STREET, LAVALE, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MSVC ROCKY GAP CEM DEC. 6 2010 FLINTSTONE, MD 22. Name and Address of Facility HAFER FUNERAL SERVICE, 21. Signature of Funeral Service Licensee 1302 NATIONAL HWY., LAVALE, MD 23a. Part 1/ Enter the diseas shock, or heart failure. complications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final theroscler Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) s been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of dertifie 29c. License number 29d. Date signed (Month, Day, Year) December 6, 200 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VIKAMADITYA POONAI, 924 SETON DR., CUMBERLAND, MD 31. Date filed (Month, 32. Registrar's Signature State inewa

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ SPURRY 1349 LEE COURTNEY NON Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. 1 M 2 X F 21 07/22/1989 216-33-1743 MD Director Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Directo 1 Yes 2X No TALBOT ST. MICHAELS MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21663 UNITED STATES 1213 WASHINGTON DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔊 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black White etc 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PROPERTY Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY MANAGEMENT 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even once. 2 SHERRY LEE HADDAWAY DOUGLAS SPURRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 509 EMORY CT., APT. 102, SALISBURY, MD 21804 DOUGLAS SPURRY/FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 11/17/2010 ST. MICHAELS, MD OLIVET CEMETERY 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 MERCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TRAUMATIC BRAIN INJURY -₽nysiciaπ/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MOTOR VEHICLE COLLISION Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury CERTIFICATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending EJECTED FROM VEHICLE 1 Yes 2 No NOV 06 2010 0403 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ST. MICHAEL'S RD and LEEHAVEN RD 4 Homicide determined STREET e Funeral C 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV 08 2010 P25607 - MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BILGE DICLE KALYON, 22 SOUTH GREENE ST, BALTIMORE MD 21201 255 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 1 2 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38590 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 8:25 I6, 2000 ALLEN FRANCIS SMITH November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartfields Assisted Living at Fred. Frederick Frederick Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date c. (Month Da 9. Birthplace (State or Foreign **Funeral** 1√ M 2 □ F Day, Year 19 Days Hours Yrs Mary land Director 218-30-8648 91 Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified Maryland Frederick Thurmont 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 105 Sandy Spring Lane 21788 U.S.A. items ? death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or iter Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ t. Page 1 and 2 should be to treent of Health and Menta tant: If item 27 is marked jury or other traumatic ev pe Allen Russell Smith Mazie Viola Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6739 East South Clifton Road, Frederick, MD 21703 William Fout, Jr. / Great Nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Germantown Ch. of God 11/20/2010 Cascade, Maryland 21. Signature of Funeral Service Licer ROBERT E. DAILEY & SON FUNERAL HOMES 615 EAST MAIN STREET, THURMONT, MD 2 23a. Part 1. Enter the disease, or complice the ck, or heart failter. Its only one callmmedithe Cruse (Final o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or imjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Q Pregnant at time of death
Unknown Month Day Year page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 Yes 2 No or Attending Physician; director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 8 No Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injuly occurred Natural 5 Pending work death. 1 Tes 2 🗌 No hours after death uneral Director: A the f 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Hospital Medical 29a. Certifier Decertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Gertifying Nurse Practioner: To the cases of the knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the cest of the knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the cest of the knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number U ,421 pleted cause of death (Item 23a) (Type, Print) 30. Name and address ss of perso

State

Registrar

Casper Cline,

31. Date filed (Month, Day, Year)

MD

19

NOV

32. Regissar's Signature

300 West Ninth Street, Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Shields Mildred Bjornson November 2010 4:45 A. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Asbury Solomons Health Care Center Calvert Solomons Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Hours Min. 0471571922 Minnesota Director 503-16-2249 88 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 11750 Asbury Circle Suite 110 U.S.A. 20688 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 1 ☐ Yes 2 💢 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edwin Ben 01son Bjornson Josephine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward B. Shields, Jr., 7025 Decoy Drive, Owings, MD 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) So. Memorial Gardens 11/23/2010 Dunkirk, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Ligens 8325 Mt. Harmony Lane, Owings, 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or liniury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) certificate has been signed by the irrector, page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spe မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending work? 1 Natural 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year)

Registrar

State

REDERICK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 22

32. Registra

Dr John 1 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylar	•				lental Hy	giene		38592
			Registrar 1. Decedent's Name (First, Middle	Last)		Cer	tificate o	T Death	7	2. Date of De	Reg. No	3 1 0	
	ysicia		, ,	ence	Stotle	r Tr					er 26,	2010	3. Time of Death 10:50 A M
	Medic xamin		4a. Facility Name (if not institution			J. J. L.	4b. City, Towr	or Locatio	n of Death	NOVEMB		inty of Death	
1	Admini	C.	14032 Village	Mill Dri	ve Apt.	403	, ,	nsvil				hingto	
Fu	neral		5. Social Security Number	6. Sex 1 ፟ M 2 ☐ F	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Und	ler 24 Hrs.	8. Date of Bir	th V Voorl	9. Birth	place (State or Foreign
Dire	ector		213-24-8098	1 LOUM 2 L.J.F	85	Yrs.	WORKIS	ys Hours	iviiti.	(Month, Da	1925	Mary	Tänd
p.	at	ž	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Loc	ation						10d. Inside City Limits
laryla	ified	Director	Maryland Washi	ngton	Me	augansv	111 ₀						1 💢 Yes 2 □ No
the M	or 22 e not	늅	10e. Street and Number	ington	Fic	augansv	10f. Zip Cod	e			10g. Citizen	of What Cou	ntry?
with	ms 23a or 28a-1 snow must be notified at	Funeral	14032 Village	Mill Dri	ve Apt.	403	2176	7			U.S	.A.	
Z1Z15-UU36 within 72 hours after death with the Maryland giene.	mer m		11. Marital Status	Armed F	edent Ever in U.		Vas Decedent of Yes, specify C			cify Yes or No- Rican, etc.)		Race - Ameri Black, White,	
after	xamii	d by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	ied 1 X Yes If Yes, Gi	2 🗆 No 194	44- 1	☐ Yes 2X			, ,	Spec	ify.	
215-0036 in 72 hours after e.	ature ical E	Completed		Year or D	ates. 194		ent's Usual Oc	cupation			16b Kind o	f Business In	ite
(12)	an "n Medi	du	(Specify only higher Elementary/Seconday (0-12)		<u>f)</u> 1-4 or 5+)	(Give I	ind of work do NOT use retir	ne during m	ost of worki	ng	l 100: Kind 0	i Business in	ladasiry
withi /giene	t, the		8			Craft	sman				Cons	tructi	Lon
Viand	even	To Be	17. Father's Name (First, Middle, L	ŕ				1 '		e (First, Middle,		ame)	
d Mer	тагк татіс		Emory Clarence		r, Sr.	T				ay Thom			01767
Mar 2 shou Ith and	traur		19a. Informant's Name/Relationsl Jean E. Stotler									•	Code) 21767 nsville, MD
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with Health and Mental Hygiene.	other		20a. Method of Disposition	•		Place of Dispo	sition (Name of			Date Apt		on - City or T	
mo Page lent o	nt: II ry or		1 X Burial 2 Cremation 4 Donation 5 Other (S		1 State		natory or other p Cemete		11/3	0/2010	Roons	horo.	Maryland
altimor	Important; if its any injury or of once.		21. Signature of Funeral Service L) 1000								Home, PA
n 881	E 8 6	1	Value	aprille	6/	7	606 01d	Nati	onal :	Pike Bo	onsbor	o, MD	21713
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that nly one cause on g	aused the dear ach line.	th. Do not ente	r the mode of o	lying, such a	as cardiac o	r respiratory ar	rest,		Approximate Interval Between
	Immediate Cause (Final disease or condition Cardio bulling and al-											Onset and Death	
	edical niner		resulting in death)		(or as a cons. q		9	_			1		
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of the period	the burial-transit	dical Examiner		L d R.									
oo/o	as #	on I	IF FEMALE:										
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. BOX le death of	shed f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unk	gnant at time of nown	death 5 L	Other (specify					, , , , , , , , , , , , , , , , , , ,	July 15ul
that the	detac	y Ph	Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cause	given in Pa	art I.	23e. Did t	obacco use c	ontribute to t	he cause of death?
uires t	ald be	q pa								1 🗆	Yes 2 N	o 3 🗆 Pro	bably 4 🗆 Unknown
w req	shou	plet								24a. Was		b. Were auto	ppsy findings available ompletion of cause of
VICAL RECORDS, ysician: The law requirer	sage (Completed by								autor perfo	rmed?	death?	
Sian:	ctor, p	Be (25. Was case referred to medical examiner?	Tree or a			26	. Place of D	eath (Check		1 3.	anne	y reprises
hysic	al dire	၉	1 X Yes 2 □ No		Inpatient 2		t 3 🗆 DOA			me 5 Resid			y)
VISION OF or Attending Place death.	funera	Certificate:	27. Manner of Death Natural 5 Pendin	9 '	of injury oth, Day, Year)	28b. Time of injury	l w	njury at ork? ☐ Yes 2		28d. Describe h	now injury occ	urred	
Vittend	y the	rtific	2 ☐ Accident Investion 3 ☐ Suicide 6 ☐ Could	not be	e of Injury - At he	ome, farm, stre				28f Location (5	Street and Nu	mher or Rura	Il Route Number,
alor/ safter	dinb		4 L Homicide determ	ned build	ling, etc. (Specif	y)	,,,			City or Tov		71207 07 7 707 0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
UNISION Of VITAL RECORDS, F.O. BOX 08/100 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	former a mera process. They are the completed filled in by the funeral director, page 2 should be detached for use as it	Medical		Physician: To the									ed. ause(s) and manner stated.
the H hin 24	пріете	Me	only one) 3 Certifying	Nurse Practioner	To the best of m	ny knowledge, c	eath occurred a	t the time, da	ate and plac	e, and due to th	e cause(s) and	I manner as s	tated.
o k o	2 8		29b. Signature and title of certifier	0 =				nse number			29d. Date sig		Day, Year)
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Registrar
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egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 45 PM 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death House OSPice Talbot ton . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 Months Hours Country) Director Mary Usual Residence of Decedent or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Funeral Director 1 ☐ Yes 2 No bot on 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' Black, White, etc. 2 No Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify: "natural", 3 ₩Widowed 4 □ Divorced Year or Dates lack other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) be filed within Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nanc Page 1 and 2 should f Health and Nitem 27 is me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 50 rnice лмме Baltimore, item 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility HOM uneral MD.21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) þ ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? HOSPICE 2 X No Hospital: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 РМ November 1:14 Cathy Lynn Tuel Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ann Arundel Medical Center Anne Arundel Annapolis Social Security Number Age (In yrs. last birthday) 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 0ays Hours 111/15/1962 Pennsylvania 47 Director 217-72-7232 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "notice." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1507 B West Street 21401 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cashier Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry L. Granville Carole Bortree 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole E. Granville/Mother 6270 Alpine Court, Sunderland, Maryland 20689 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Mt. Zion U.M. Church Cem. 11/12/2010 Lothian, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 X No
9 Unknown Ectopic pregnancy Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? 2 🗌 No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 certificate

cate has been signed by page 2 should be detac eral Director: After this certific filled in by the funeral director,

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Certificate: To I within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keith Goulet, 600 Ridgely Avenue, Annapolis, Maryland

26. Place of Death (Check only one)

2 🗌 No

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Other:

1 🗌 Yes

28c. Injury at

State Registrar

31. Date filed (Month, Day, Year) NOV 1 2 2010

25. Was case referred to dical

2/₩ No

5 Pending

Investigation

Could not be

determined

examiner?

1 🗌 Yes

27. Manner of Death

Natural

2 Accident

4 Homicide

3 Suicide

1 npatient 2 ER/Outpatient 3 DOA

28b. Time of

28a. Date of injury (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene (38596 AMEND#26 per FH 11/18/2010 Certificate of Death AACO HEALTH DEPT OMH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician HOMP SON MACK 13847 Ra 12 2010 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) Examiner PRINCE GOODS HEALTH Bowil CENTER Bowie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. lest birthday) **Funeral** Days Hours Months Yrs. Director 227-28-2232 81 Mar. 26, 1929 Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits f Haalth end Mentel Hygiene. Item 27 is marked other than "natural", or frems 23s or 28s-f show other traumatic event, the Medical Examiner must be notified as 1X Yes 2 □ No Funeral Director Prince George's Bowie 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 12107 Forge Lane 20715 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. Armed Forces 1 1∑Yes 2 □ No If Yes, Give Yeer or Dates:1945-73 1 Never Married 28 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: White Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military Police U.S. Army 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George C. Thompson Chloe Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Betty J. Thompspn / Spouse 12107 Forge Lane, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages Department of Important: if its any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory 11/15/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Beall Funeral Home 21. Signature of Funeral Service-Licensee 6512 NW Crain Hwy., Bowie, MD 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) ar DIODUM monary Examiner Examiner pidenia or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Division of Vital Records, P.O. Box 68760. ension Physician/Medical Due to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was en autopsy 1 Yus 2 No 1 ☐ Yes 2 ☐ No cartificate 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To 1 ☐ Yes 2 € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 € DOA After this 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier completaly (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier no completed ceuse of death (Item 23a) (Type, Print) 30. Name end eddress of person Downe 1-LYON 1500 DRIVA PAU HEALTH CENTER 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State NOV 1 8 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:15 IAR GARET OVAIO 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ک` Sex 1 ☐ M 2 🔀 F If Unde 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 90 579-16-5801 Months 01/06/1920 Maryland Director Usual Residence of Decedent or items 23a or 28a-f show 10h County or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27671 Polo Court 21801 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Yes 2 No Specify. Specify white Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 homemaker domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Massimo DeMichele Benedetta DiDomenico 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) roiano Sandy Fitzgerald-Angello daughter 4110 Rivermare Lane, Eden, MD 21822 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury o 4 Donation 5 Other (Specify) Cedar Hill Cemetery 11/23/2010 Suitland, MD nature of Funeral Service Licensee Name and Address HOLLOWAY Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 Domoso 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ PULMONARY 11320515 disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Live Birth 2 - Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Unknown 1 Yes 2 No 3 Probably Completed peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? After this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 's Dother (Specify) HOSPICE completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred ✓ Natural 5 Pending work? 2 No Accident Investigation Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or important in the cause of examination and or importa Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOP v 3 Hugan 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 3 Registrar

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Physicia		Decedent's Name (First, Middle)	e,Last)							. 2	. Date of Dea	ath			3. Time of Death
Medical Exami	ner	Jarr	ell Calvi	n Waldr	on						Month Novembe	Day er 22,	2010 Yea	,	0921 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of D									f Death				
		110 Lakeside Drive					North	East					Cecil		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYY									//DD/YYYY	g. Birl	hplace (State or Dak HIII		
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fu l	ł	10a. State 10b. County		10c. City	, Town	or Locatio	on					_			10d. Inside City Limits
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ylanc n-f sh	흱	Maryland Ceci 10e. Street and Number	.1			No.	orth 10f. Zip		t			10a Ci	tizen of Wh	at Cour	
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s afte	Š		orced If Yes, Give Yes or Dates:						specify:			Lou	Specify:		ite
hour	P G	15. Decedent's Education (Spec Elementary/Secondary (0-12)								kind of wor use retired		166.	Kind of Bus	siness/ii	ndustry
36 in 72 han '	Completed		College (1-4 or 5+)		Mode	. +		Man			Ι,	Indust		1
with with Mer t	E	12 17. Father's Name (First, Middle,	1			Mail	псепа			la Nama (F	First, Middle,				т
H. H. B.		Unknown	Last)						ro.iviotriei		Unknow		i Surriame)		
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nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland art of Health and Mental Hygiene. It: If item 27 is marked other than "natural", or items 23a or 28a-f show any other transmatic event, the Medical Examiner must be notified at once.	리	Rachel Miller	,	r							ilburr				30047
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S l s of H		1 Bunial 2 Cremation	3 Removal fr	om State	cremato	ry or othe	er place)			Novem				•	
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Physician	25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												ırt	Approximate Interval Between Onset and	
Examiner	ı												Death		
	- 1	or condition resulting in death)	Due to (or as a	consequence of	of):										
	ᆈ	Sequentially list conditions, if any, leading to immediate	b. Due to /or as s	consequence of	νf)·									_	
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3760, ficate be g physici s the buri	₽ i	IF FEMALE:		outcome of preg								23	3d. Date of	delivery	
687 ertifi ding	ian	23b. Was decedent pregnant in th past 12 months?	Dress		4.0	Feta	death	3	Ectopic	pregnanc	У		Month	D	ay Year
Box 68 e death certi the attending ed for use as	Sic	1 Yes 2 No 9 Unk	nown g Unkn	nant at time of de	eath 5	Othe	er (Speci	ify) _							
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Vital Rec ysician: The l his certificate director, page	e Be	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Ou	tpatient	3 DC	DA C	Other ₄	Nursing I	Home 5	Resid	ence 6 🗸	Other:	Scene
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be deaced.	٢	27. Manner of Death	28a. Date	of Injury	28b. T	ime of Inj	ury 2		y at Work		Bd. Describe				
ath.	흲	1 V Natural 5 Pend	ing	, Day,Year)				1 Y	es 2	No					
Vision or Attene free death Director: in by the	<u>[2</u>		tigation 28e. Plac	e of Injury - At h	ome, far	m, street,	, factory,	office bu	uilding, etc	c. 28	3f. Location (Street a	and Numbe	r or Rur	al Route Number, City
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Hospi 4 hou Funer	알	20a Certifier	nysician: To the bes	at of my knowled	ge, deal	th occurre	ed at the	ime, dal	te and pla	ce, and du	ue to the caus	se(s) aı	nd manner	as state	id.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	one) 2 Medical Exam	miner: On the basis	of examination a											
To To	Me	29b. Signature and title of certifie	and manner s	lated.			29c.	License	e number			29d.	Date signe	d (Mon	th, Day, Year)
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		30. Name and address of person	who completed accord	se of death (ltc=	1 2321			_				1			
10+1VA			Assistant Medic			1 Penn	Street	, Baltiı	more, M	/ID 2120)1				
				egistrar's Signati				, _ = =====							
Sta	ate rar	31. Date filed (Month, Day, Year) NOV 2 3 201	0 6	sgisti di S Sigilati											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Physician/ Matilda Ann Wilhite November November 18 2010 12:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 31 West Patrick Street, Apartment 507 Frederick Frederick If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Days Hours April 10, Yel 925 351-16-3593 85 Illinois Director Usual Residence of Decedent or 28a-f show 10b County 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Frederick Frederick 1 **X** Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 31 West Patrick Street, Apartment 507 21701 United States of America death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after White 1 Yes 2 No Specify. Specify: "natural" Completed 3 K Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 I h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Education Counselor Education injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanley Biel Anna Pudlowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau James Wilhite / Son 2231 Bear Den Road, Frederick, Maryalnd 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arlington National December 8, Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 2010 Signature of Funeral Sep Reeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami -transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes Should Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performe this certificate 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 2 1 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending atural work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A

completed filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

Registrar

State

45 Thomas Johnson Drive, Frederick, Maryland 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

0

William H. Convey, M.D.

NOV

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

		-	For State Registrar	Cert	tificate of D	eath		Reg. No.2	10	386	00
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of De NOV •	o ¹⁹ , 2	∪ },dd l	3. Time of 3:40	Death A M
	Medic	al	Julia Lee Waddington 4a. Facility Name (if not institution, give street and number)	Т	4b. City, Town, or	ocation of Death	NOV.		ty of Death	3.40	A M
_)	Examin	er	1271 Cove Drive		Churcht			1	Arun	del	
	Funeral		5. Social Security Number 6. Sex 7. Age (II	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 4/20/	th	9. Birth	olace (State o	r Foreign C
	Director		578-44-5907 The Martin Part of Decedent	75 Yrs.			4/20/	1935		1	,,
	f shov	tor		Oc. City, Town or Loca					1	I0d. Inside Ci	
	Many 28a-	Director	MD Anne Arundel	Chu	rchton 10f. Zip Code			10g. Citizen of	: \\/\- at C at 11	1 🗆 Yes	XX No
	with the	eral [1271 Cove DR.		101. 21p Code	20733		U	J SA	itry ?	
	items	Funeral	11. Marital Status 12. Was Decedent Ever Armed Forces?	r in U.S. 13. W	/as Decedent of His Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Ra	ce - Americ		
2	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 Never Married 2 Married 1 Yes 2 XXNo If Yes, Give Year or Dates.		☐ Yes 2. XX No			Specif	r	√hite	
5	72 hou "natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give ki	ent's Usual Occupa ind of work done du ONOT use retired)	tion uring most of work	ing	16b. Kind of I	Business In	dustry	
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2	filed v al Hyg d othe) Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Surnan	ne)		
yla	uld be I Ment narke natic	입	John Henry Rosner			Mary Lo					
2	2 shoilth and the street of th		19a. Informant's Name/Relationship (Type, Print) Linda Dinges Daughter		g Address (Street a. Cove. Dr.			nr, City or Town, 1D 20733		Gode)	
ນົ	1 and of Heal item other		20a. Method of Disposition	20b. Place of Dispos			Date	20c. Location		own, State	
	Page ment c ant: If ury or		1 ☐ Burial 2 ★★ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Atlantic	Crematory	7 11/1		Glen I			
Daltillo	permit. Departimport Import any inj		21. Signature of Funeral Service Licensee		Name and Address		-			P.A.	
			23a. Part 1. Enter the disease, or complications that caused th		2 Ridgely r the mode of dying				21401	Approximat	
	nysician/		shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition	COP	20					Interval Bet Onset and	
	Medical Examiner		resulting in death) Due to (or as a co	onsequence of):							
	ed sit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	onsequence of):							-
	ficate be executed g physician and as the burial-transi	Aedical Examiner	that initiated events c. Due to (or as a c	onsequence of):							
200	ate be	edic	d								
00	certific nding use as	-	IF FEMALE: 23c. If yes, outcome of		Estania programa			23d. D	ate of deliv	rery	
. DOX	the atte	Physician/	in the past 12 gronths? 1 Yes 2 No 9 Unknown	☐ Fetal death 3 ☐ me of death 5 ☐	Other (specify)			N	onth	Day	Year
ŗ. 5	that the	by P	Part II. Other significant conditions contributing to death but			1 .		obacco use cor			
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Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed					24a. Was auto perfe		prior to co death? 1 \square Yes	ppsy findings a empletion of c	available ause of
VII.ali r	sian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner? Hospital:			ce of Death (Chec					
_	Physic this or	6	1 ☐ Yes 2 X No 1 ☐ Inpatient 27. Manner of Death 28a. Date of injury	2 ER/Outpatien	t 3 DOA Othe	4 ☐ Nursing Ho		dence 6 🗆 Ot		y)	
0H 0F	ending eath. or: After the funer	Certificate:	1 Natural 5 □ Pending (Month, Day, Y 2 □ Accident Investigation 3 □ Sulcide 6 □ Could not be		work'		Zod. Describe	- Injury cood			
DIVISION	al or Att	7	4 Homicide determined 28e. Place of Injury building, etc. (s	- At home, farm, stre Specify)	eet, factory, office		28f. Location (City or To	Street and Num wn, State)	ber or Rura	l Route Numb	per,
	Hospit 24 hour Funera leted fills	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check only one) 3 Certifying Nurse Practioner: To the be	mination and/or investi	igation, in my opinio	n, death occurred a	t the time, date	and place, and c	lue to the ca	ause(s) and ma	anner stated.
	To the within To the comp	2	29b. Signature and title of certifier	1 1	29c. License	number		29d. Date sign			
	78		Marry & Sleenge	lel Mo	1 6	10515	8	11/9/	201	10	
	410		30. Name and address of person who completed cause of dear		rint) 6/ SH/	70515 31 2	r my	70	20	76	4.
	Sta		31. Date filed (Month) Day, Year) 32. Registrar's		6-41	-/					

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar 38601 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0550 4N 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign Country)
 NJ Days 1 🔀 M 2 🗆 F 01(M/3th, P9.46r) 145-36-7652 64 **Director** Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 Yes 2 No <u>Anne Arundel</u> Annapolis ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 668 Red Cedar Road 21409 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 5 þ 1 Never Married 2 X Married Yes 2 No Yes, Give 70 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", Completed 70-74 White 3 Widowed 4 Divorced Year or Dates. event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry should be filed within 12... h and Mental Hygiene. (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Information Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Walter Williams Emily Nugent Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Carol Williams - spouse 668 Red Cedar Rd. Annapolis, MD 21409 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Atlantic Crematory 11/14/2010 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty F.H. 12 Ridgely Ave, Annapolis,MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or a s a consequence of): the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Day Month Year Pregnant at time of death P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate | 1 Yes 2 ☐ Yes completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident Suicide work? injury 5 Pending 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 🛮 🚾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) SOUNE. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ritchie 21012 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene- U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month November Year 2010 Otis Winfield 349 Watkins, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Galtimore Battimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. Months Maryland Director 216-60-3199 60 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1XXYes 2 ☐ No Maryland Randallstown Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9109 Randallstown Rd. 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Heavy Equipment Operator Construction and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Otis Winfield Watkins, Sr. Marjorie Elizabeth Jolley per it. Page 1 and 2 should re Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boonsboro, Maryland Debroah Watkins-Wife 10 Boone Place 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory Nov.24,2010 Hagerstown, Maryland Osbornea Buneral Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final respiratory failure Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner transudative pleuval effusion Sequentially flot conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown Month 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by endstage renal disease on hemodialysis 1 Yes 2 No 3 Probably 4 Unknown arreny disease, s/p CA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was referred to dical within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 1 Yes 2 No Yes Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: ျ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier RES ODO November MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ILY YUMUI, Singi Hospital of Baltiji 3H-3 Baltimore 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - State RegistraAmended item #6, WCHD, SLU, 11. Certificate of Death 29.10 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 19, Marlin W. Ward 2010 9:45 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6060 Venery Lane Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 €M 2 F Hours o1%22/1922 213-16-1390 Maryland Director 88 Yrs. Usual Residence of Decedent 28a-f show 10b. County 10a. State within 72 hours after death with the Maryland ä 10c. City, Town or Location 10d. Inside City Limits Director any injury or other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 🗗 No Maryland Wicomico Salisbury 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 6060 Venery Lane 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: white 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) secretary clerical Be 17, Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ည Harrison Crofoot Myrtle Handler 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maureen Truitt/daughter 6060 Venery Lane, Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Salisbury Crematory Salisbury, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 21 Name Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death aconsequence of): Physician/ disease or condition MINS Medical resulting in death) Due to (or as a Examiner 117715 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consedence of) and I-transit YES death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Physician/Medical attending p 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day 1 Yes 2 4 Yes 2 No ed by the a Hospital or Attending Physician: The law requires that the signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Status POST ADRIJC VALVE Replacement Records, 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 2 1 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this.

__completed filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Small M. Muy, MO 0/0688 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Donald M. Werp 400 EASTERN SHINE DRIVE, SALDBURY 32. Registrar's Signature State 2 3 2010

Registrar

Box 68760

P.O.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Patrick Adams Forrest Physician/ Month Day 10:50PM 201 ecembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Joseph Richey Hospice 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 6/01/1942 Months Hours 1 K M 2 🗆 F 197-32-9528 68 Director PA Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Funeral Director Baltimore MD 1 X Yes 2 No 10f. Zip Code 10g, Citizen of What Country? 21201 828 North Eutaw Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 XYes Baltimore, Maryland 21215-0036 п Yes, Give Year or Dates. Air Force 1 ☐ Yes 2X No Specify. Specify: Black 3 - Widowed 4 - Wivorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Licille Wells james E. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1718 Pasture Walk Dr., Wake Forest, Robin M. Gary/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Woodbine, MD Final Journey Crem. 12/10/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Derota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician. Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown or Attending Physician; The law requires that the death Month Day Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use couribute to the cause of death? þ 1 Yes 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Vital 25. Was case referred to 26. Place of Death (Check only one) a examiner? Other: 4 Nursing Home 5 Residence Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) of 27. Manne Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural injury work?
1 Yes 2 No 5 Pending Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29c. License number filed (Month, Day, State Registrar

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10-09253 Steven Allman

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State of Maryland / Department of Health and Mental Hygiene Steven Allman 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day December 2, 2010 0449 hrs Medical Examiner Steven Allman 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore Washington Medical Center** Glen Burnie Anne Arundel 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Age (In yrs. last birthday) **Funeral** Davs Hours Min. Director 220-98-468 Country) 42 Yrs 11/18/1968 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 224th Street 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces' Pages 1 and 2 should be filed within 72 hours after death 1 X Never Married 2 Married 1 X Yes White 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ment of Health and Mental Hygiene.

fant: If item 27 is marked other than "

or other traumatic event, the Medical. Contractor US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert G. Allman Linda Gunter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda J. Allman (mother) 224th Street, Pasadena, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Burial 2 X Cremation 3 Removal from State Dec. 02 permit. Pages Department of Important: I Metro Crematory Inc. Donation 5 Other Specify Baltimore, Maryland 2010 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval . Part I. Enter the disease, or complications **Physician** failure. List only one cause on 9 en Onset and ach line /Medical Mixed Drug Intoxication (Morphine, Tramadol) Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit Medical X UNPENDED 28a-f per ME G911 1/11/11 MAM Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the Physician/ Live birth 3 Ectopic pregnancy Day Fetal death Month Year past 12 months? Pregnant at time of death 5 Other (Specify) For Yes 2 No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 6 1 Yes 2 No 3 Probably 4 Unknown page 2 should be Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of has performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 26.Place of Death (Check only one) 25. Was case referred to medical of Vital funeral director, Be examiner? Other Nursing Home 5 Residence 6 Other 1 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a, Date of Injury (Month, Day, Year 28d. Describe how injury occurred Natural Division Pending 1 Yes 2 X No fd 12/2/10 fd.4:00am the 2 Accident Investigation Certifica 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide 811 204th st. Pasadena, MD Residence determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. December 2, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Melissa Brassell, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month) State 0 9 ZUTU Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a 5 fate of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 20 Physician/ (M Medical 4a. Facility Name (if not institution, give street ar 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Oak Crest Village Parkville 8. Date of Birth May 16, 1915 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗑 F Hours 95 Yrs Director 147-28-8352 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director MD 1 🗌 Yes 2 😿 No Baltimore PArkville 10e. Street and Number 10g. Citizen of What Country? ō Funeral 8832 Walther Blvd RGN322 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: American Indian Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>teacher</u> education and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8832 Walther Blvd Parkville, Oak Crest Village MDBaltimore, 20a. Method of Disposition
1 ☐ Burial 2 ★ remation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) in state 12/09/2010 | Woodbine,MD Fīnal Journey Crem. 22. Name and Address of Facility Mary Land Cremation Services State Anatomy Board 555 Williams Street Baltimore Street Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician/ Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; After this certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ုင 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 27. Manner of Death Certificate: 28d. Describe how injury occurred injury 1 W Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check cnly one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 04, 2010 9:15 A M ABEL RITH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SUNRISE ASSISTED LIVING COLUMBIA HOWARD 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 12771571925 Director 128-16-2069 84 NY Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No BOYNTON BEACH FL PALM BEACH 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 5087 PELICAN COVE DRIVE 33437 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🏋 No Specify: 3X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BRODER ISRAELSON ISRAEL ANNA injury or other traumatic t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7099 GARDEN WALK, COLUMBIA, MDRONNIE SANDERSON/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place X Burial 2 Cremation 3 X Removal from State 4 Denation 5 Other (Specify) BETH DAVID CEMETERY : 12/8/2010 ELMONT, NEW YORK 21. Signature of Funeral Service Ucen. 96 22. Name and Address of Facility SOL LEVINSON & BROS., any in once. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or somplications that caused the 🗸 ath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart-failure. List only one cause on each Inc. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 \(\subseteq \text{ Yes} \quad 2 \subsete \text{ No} \) 5 Other (specify) Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has performe 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred iniury 1 Natural 5 Pending 2 No Investigation Accident completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) of certific 29b. Signature and title 29c. License number ND 30. Name artherers of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month Carol L. Bauer Dec 10:30å Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 816 Arncliff Road Essex Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In vrs. last birthday) 8. Date of Birth **Funeral** 218-70-8563 1 ☐ M 2 🕞 Months Days Hours Min. Dec. 20, 53 Director MD Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5912 Farmview Avenue 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Senior Records Clerk 12th Calvert School Be '. Father's Name *(First, Middle, Last)* Harry Zimmerman 18. Mother's Name (First, Middle, Maiden Surname) ပ Thelma Oliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Bauer /husband 5912 Farmview Avenue Baltimore MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gardens of Faith 12/9/10 4 ☐ Donation 5 ☐ Other (Specify) Rossville MD 21. Signature of Funeral Service Hoersee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the Seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Immediate Cause (Final Modignant Onset and Dath Physician 4845 disease or condition resulting in death) IMENUM Medical Due to (or a ser consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Numiparasis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a. Was an autopsy

Division of Vital Records, P.O. Box 68760
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Certificate:

Medical

Baltimore, Maryland 21215-0036

1 Natural 5 Pending Investigation 3 Suicide Homicide Homicide Homicide Suicide A Could not be determined Homicide Homici

29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

December 8, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAISHEL BLANETEY 1550 ORLEANS STREET SUITE IMIG BALTIMORE MARYLAND 21231

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b-f, perFH, G910, 12/13/2010, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Day Amelia R. 2:00 A M Battye 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Union Memorial Hospital **Baltimore** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 2 Months Days Hours Min. Oct. Yea 1916 94 Mary land **Director** 218-03-3108 Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes ANO Baltimore Lutherville Maryland Baltimore 10e. Street and Number 700 West 40th Street 21211 21093 9 10g. Citizen of What Country? "natural", or items 23a o Funeral U.S.A. 510 College Avenue 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Armed Forces?
1 ☐ Yes 2 ▼ No Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 № No Specify: If Yes, Give Year or Dates White 3 ¥ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene rant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pauline Witzel Gabriel Leo Rettaliata 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Susan A. Battye / Daughter 510 College Avenue Lutherville, Maryland permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Hilltop Service Corp 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State 12-6-2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rick Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Urosep 5:5 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** hypotension Sequentially list conditions Examine if any, leading to immediate burial-transi Cause (Disease or iinjury that initiated events HYBOXIA To the Hospital or Attending Physician: The law requires that the death certificate be executed 2 hours attending physician and Due to (ox as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year sate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 🗌 Yes ၉ 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie AT2438946 12,02, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pere MD 201 Raltimore Gonzalo Universi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type of Print in Black Indelible ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene in amend #10f Per FH G210 title atte 610 eath 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6, Deborah L. Brown Dec. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 8354 Sycamore Road Millersville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, May 27 **Funeral** Year) 1 □ M 2 🔀 F Months Days Hours Min. 47 -42 Director 220-92-2819 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Directo Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 21108 8354 Sycamore Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Machine Operator Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Whittaker Helen Hoffman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Helen T. Whittaker (mother) 8354 Sycamore Road, Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State Dec. 10 Glen Haven Cemetery 4 □ Donation 5 □ Other (Specify) Glen Burnie, Maryland 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the disase, or comshock, or heart failus List only complic to s by a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one can be on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of)

and manner stated.

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Examiner

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Physician/Medical φ Completed Be 2 completely filled in by the funeral Certification:

2

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Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

DEC 0 9 2010

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

Director:

within 24 hours a To the Funeral I

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 9 □ Unknown		23d. Date of delivery Month Day Year					
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death? 2 No 3 Probably 4 Unknown					
		24a. Was an autopsy performed?						
25. Was case referred to medical examiner?	26. Place of Dea							
1 Yes 2 XNo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Specify)					
27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how inj						
3 Suicide 6 Could not b 4 Homicide determined								

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3. Time of Death

Birthplace (State or Foreign Country)

CT

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2x No

03:55 Рм

^{Day} 2010^{Year}

1963

4c. County of Death

Anne Arundel

USA

Manufacturing

29d. Date signed (Month, Day, Year)

Specify:

14. Race - American Indian Black, White, etc.

White

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ Cynthia Brown 2010 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Stella Maris Hospice Timonium Baltimore 5. Social Security Numbelunk 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, une 29 Days Hours Year 1 □ M 2 🔀 F Yrs. Director 53 Pennsylvania <u>June</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at death with the Maryland Director 1 ☐ Yes 2 📈 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21234 6804 Old Harford Road USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 XMarried filed within 72 hours after Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify: black "natural" 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) healthcare nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alnora Williams Y.C. Allan Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6804 Old Harford Road Baltimore, MD Kevin Mooney/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1
Burial 2 Cremation 3 Removal from State 4 X Donation 5 Sther (Specify) Signature of Funeral Services ce Licensee S - Wade State Anatomy Board 655 W. Baltimore Street Raltimore MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause on each line Interval Between Immediate Cause Final disease or condition resulting in death) Onset and Death Physician/ SARCOIDOSIS Medical Due to (or as a consequence of) Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) s been signed by the s should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? Yes 2 X No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending injury Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🛣 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

JACKIE JONES,

09

31. Date filed (Month, Day, Year)

CRNP

NOVEMBER 27,

CYNTHIA BROWN

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 20TO 5:05 PM M Robert Lee Bowers Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Veteran's Home Charlotte Hall Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Days Hours FEB 3 Mary Tand 1928 Director 82 215-20-7616 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 😿 No MD St. Mary's Charlotte Hall 10f. Zip Code 10g. Citizen of What Country? Funeral 29449 Charlotte Hall 20622 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 Never Married 2X Married Completed by 1 Y Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced Specify: white 45-69 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) un 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) engineman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Albert Lee Bowers Nellie Shank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $14855\ Patuxent\ Ave\ Box\ 215\ Solomons,\ MD\ 20688$ Fladys Bowers/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signatu e of Funeral Servio Licen State Anatomy action 655 W. Baltimore Street Director MDBaltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) delanud Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【☆No 24a. Was an autopsy after death.

Director: After this certificate I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and little of certifier 29d. Date signed (Month, Day, Year) 124/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLOTTE RO MACI CHARLOTTE 20622 32. Registrar's Signatur 9 201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7 Month Year Physician/ Nancy Campanella 4.30 M Drambe 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Season's Hospice Randallstown g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Months Hours Min New Jersey 03/06/1949 Director 136-42-4312 61 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Owings Mills 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? $U \cdot S \cdot A \cdot$ Funeral 9415 Owings Heights Circle, Apt 304 21117 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeper Heating/Air Condition Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Cangelosi 2 Thomas Castaldo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Tersigni/Son 9415 Owings Heights Circle, Apt. 304, Owings Mills 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/09/2010 | Hanover, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Lung (anul Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to for as a consequence on cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3
 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant g Unknown Month Day Year Pregnant at time of death 5 Other (specify) ☐ Yes ☐ ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an autopsy performed After this certificate has 25. Was case referred to predical examiner? 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending after death Accident Investigation ☐ Acciden
☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) ว4 hours a e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) Wilajapanem.o D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S. Rey apake MP 28355mim MV 5-203, Balamore mo 21208 N. S. Rigapakse MP 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 9 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER Peter Raphael Cordova Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GLEN BURNIE BALTIMORE WASHINGTON MEDICAL CENTER ANNE ARUNDEL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** 06/14/1958 1 🔀 M 2 🗆 F Hours 215-82-6196 Director Usual Residence of Decedent 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland by Funeral Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 8135 Harold Court 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after timore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygien Important: If item 27 is marked other t any injury or other traumatic event, the once. Computer Technician Micro Systems Be CORDOVA, YETER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harold Philip Cordova Marian Aurelia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris H. Cordova/Brother 6044 Lucerne Street, Jupitor, FL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/4/2010 | Hanover, Maryland Ardent Cremation Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or computations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death MONINGINS Physician/ disease or condition resulting in death) ➤ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of): the attending physician and the for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical vision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month 1 Yes 2 9 Unknown Pregnant at time of death Dav Year 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 NO 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of ne High or Attending P n 24 hours after death. 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 1 🔼 Certifylng Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of dertifie 29c. License number 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MSULTOUR BAZIMONE MINVUIT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MID

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Arunde)

White

Onset and Death

Day

2 🗌 No

1 🗌 Yes

Year

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 🔀 No

0845 AM

2010

DHMH 17 Rev 7/2009

State Registrar BAltimore Washington Marical Center

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland / Dep		Mental Hygien	e 2010 20010				
		_	Registrar 1. Decedent's Name (First, Midothe, Last		rtificate of Death	Reg. N					
	Physicia Medi		LINWOOD Car	pbe 11		Month D	Pay Year OZ: 10 AM				
	Examir		4a. Facility Name (if not institution, give s		4b. City, Town, or Location of Dear		c. County of Death				
				medical CENTER 7. Age (In yrs. last, birthday)	Towsok If Under 1 Year If Under 24 Hrs		BALTIMORES COME OF THE PERSON				
	Funeral Director		216-76-9604 17	T. Age (In yrs. last birthday) 53 Yrs.	Months Days Hours Min		9. Birthplace (State or Foreign Country)				
	nd how at	r	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits				
	Aarylar 8a-f sl tified	Director	MD	Baltin	10re		Yes 2 □ No				
	the Na or 2 be no	al Dii	10e. Street and Number	O. al	10f. Zip Code	10g. (Citizen of What Country?				
	ath with	Funeral	36/8 CIEARSPVIR	Was Doodont Ever in U.S. 12	Was Decedent of Historia Origina (S	positi Vos er No	<i>USH</i>				
9	within 72 hours after death with the Maryland gjene. er than "natural", or items 23a or 28a-f sho t the Medical Examiner must be notified at	by F	1 Never Married 2 Married	1 Ves 2 M No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - American Indian, Black, White, etc.				
21215-0036	ours af tural", al Exa	ted	3 Widowed 4 Divorced	Year or Dates.	1 ☐ Yes 2 No Specify:		Specify: Klack				
15-	72 hc an "na Medic	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	de completed) (Give	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	Kind of Business Industry				
212	ed within Hygiene. other tha		Elementary/Seconday (0-12)	College (1-4 or 5+) FOV	KLift Operati	or t	thacus				
Maryland	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last)	uphall	18. Mother's Na	me (First, Middle, Maidei	O. W. O.				
ary	should the and Meis mark	ľ	19a. Informant's Name/Relationship (Type	pe, <i>Print</i>) 19b. Maili	ng Address (Street and Number or Ru	ural Route Number. City of	or Town, State, Zip Code)				
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was a series as a series of the transmerted other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Rosezena Car	mpbell 5618	Clearspring Ro	1 72~11	More Mary land 21212				
Baltimore,	0 0 = =		20a. Method of Disposition 1 X Burial 2 Cremation 3	20b. Place of Dispo Removal from State	matory or other place)	Date 20c.	Location - City or Town, State				
Him	permit. Page Department o Important: If any injury or once.		Donation 5 ☐ Other (Specify) 2 Signature of Funeral Service Livense	Hrbutt	Name and Address of Eacility	10/10 mu	HIMOVE, Maryland				
Ba	permit. Departn Imports any inju		2. Orginature of Furieral delivide Elegine	1/	aughn C. Greene	F.S. day	Fimore, Md- 21212				
			23a. Part 1. Enter the disease, or compleshook, or heart failure. List only on	ications that caused the death. Do not enter cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between				
2	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)		ICER	_	Onset and Death				
	Examiner		To suiting in deathy	Due to (or as a consequence of):							
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):							
D	and transi	Examine	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequence of):							
0	Attending Physician: The law requires that the death certificate be executed redeath ar death. stor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	dical E	resulting in deathy Last	4							
8760	ificate ng phy as the	Medi	IF FEMALE:	J							
Box 687	eath certifica attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy		23d. Date of delivery Month Day Year				
	that the dea ned by the a detached f	ηsic	1 Yes 2 No 9 Unknown	4 Pregnant at time of death 5 December 19 Unknown	Other (specify)		Month Day real				
P.O.	ires that the signed by do be deta	by Pi	Part II. Other significant conditions cor	ntributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?				
Records,	requires been sig should b	ted				1 ☐ Yes 2	Probably 4 MUnknown				
000	law re has be je 2 sh	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?				
<u> </u>	ician: The la certificate ha ector, page		25. Was case referred to medical		26. Place of Death (Che	1 Yes 2 X					
of Vital	nysicia iis cert direct	To Be	examiner? 1 ☐ Yes 2 No	ospital:	Other:	Home 5 Residence	6 ☐ Other (Specify)				
J Of	ling Pt		27. Manner of Death 1 DaNatural 5 ☐ Pending	28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?	28d. Describe how inju					
sior	Attendii death. ctor: A y the fu	Certificate	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No eet, factory, office	28f. Location (Street as	nd Number or Rural Route Number,				
Division	al or / s after al Dire	4 Homicide determined determined building, etc. (Specify)									
_	To the Hospital or Attending Physician: within 24 hours after death within 24 hours after death. To the Funeral lite of the funeral director, completed filled in by the funeral director,	Medical	(Check 2 Medical Examin	cian: To the best of my knowledge, death of the basis of examination and/or investigation.	tigation, in my opinion, death occurred	at the time, date and plac	e, and due to the cause(s) and manner stated.				
	o the vithin 2 or the l		only one) 3 Certifying Nurse	Practioner: To the best of my knowledge,	death occurred at the time, date and pl	ace, and due to the cause	(s) and manner as stated.				
	F S F Ö		· //	6	D4635/	100	cember of 2010				
	5		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, F	Print)		Compet OU ZOIN				
			XHOSKOW TA 31. Date filed (Month, Day, Year)	BASSI MD. 70	O OSLER DRIVE	TOWSON,	MARYLAND 21204				
	Sta Registra	re.	nfc. 0 9 2010	leven J. Marke							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink I Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and Town, or Location of Death 4c. County of Death **Examiner** TIMOY 8. Date of Bi th 9. Birthplace (State or Foreign **Funeral** Months (Month, Bay Year) Country) 2010 MD Director N/A Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at **Funeral Director** 28a-f Baltimore MD NA 1X Yes 2 No 10e, Street and Number L 652 10f. Zip Code ō 10g. Citizen of What Country? items 23a U.S.A. 1653 East Belvedere Ave Apt 208 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married ō ģ Yes 2 No Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A N/A N/A alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Salimata Dieng Habib Fall 1652 Fast Belvedere Ave Apt 208, Baltimore 19a. Informant's Name/Relationship (Type, Print) f Health item 27 1653 East Belvedere Ave Apt 208, <u> Habib Fall-Father</u> other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 5 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or Memorial Park11/26/2010 Woodlawn, Md 4 Donation 5 Other (Specify) 22. Name and Address of Facility March F/H West 4300 Wabash Av ature of Funeral Service Licensee Baltimore, Md Ave 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death ck, or heart failure. List only one cause on diate Cause (Final ase or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No the funeral director, page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 X No 1 Tes 9 1 Inpatient 2 I ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident
Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗆 within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12/08/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Are, Balto, 2401 Wiselvedore Carat Welsman 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 24, 2010 Physician/ 4:30 PMM Harry W. Darby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospice of St. Mary's Calloway 9. Birthplace (State or Foreign Country) Texas 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Sept 4, 1 ₹ M 2 □ F **1**954 Director 56 483-70-8587 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2x No St. Mary's Mechanicsville MD 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20659 26718 Tintop School Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married ▼ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) church director musician Be 17. Fathèi's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margie Alice Floyd Clifton Wilburn Darby 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26718 Tintop School Road Mechanicsville, MD 20657 19a. Informant's Name/Relationship (Type, Print) Kathryn Darby/spouse 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town. State cemetery, crematory or other place) 1
Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 X Donation 5 Other (Specify) 21. Signatu Funeral Servi 25 Name and Advass of Facility Board 655 W. Baltimore Street Baltimore. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each in e. Immediate Cause (Final disease or condition Onset and Death Priysician/ a Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav Year ed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be del Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☑ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) ST Manys 202 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral (Month, Day, Year) injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident M Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29c. License numbe 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day,

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 2010 EILEEN DEBOIS 6:00 P M HELEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 79 RAISIN TREE CIRCLE BALTIMORE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**½** F Months Days Hours Min. 04/24/1928 Director 82 208-12**-**2900 PA Usual Residence of Decedent show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 🗌 Yes 2x No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 79 RAISIN TREE CIRCLE 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: "natural", 3 Widowed 4 Divorced WHITE permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MODEL FASHION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOSEPH POLLON ESTHER **MEYERS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEODORE DEBOIS/HUSBAND 79 RAISIN TREE CIRCLE, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ឺ Burial 2 🗌 Cremation 3 🗌 Removal from State Ponation 5 Other (Specify) BETH EL MEMORIAL PK 12/8/2010 RANDALLSTOWN, MD Signature of Figure 1 Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Frysician. disease or condition resulting in death) dehydration 3 de Medical Due to (or as a consequence of): Examiner roduction enteritis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed uterine circi the attending physician and hed for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 1 ☐ Yes 2 🗶 No 9 ☐ Unknown signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes 2 ☐ No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 \square Pending Accident
Suicide
Homicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kichend C Berg. " D 12/7/10 00020604

DHMH 17 Rev 7/2009

State Registrar 40; Suite 450; 10755 Fells Rd, Luthaville, hd 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berg

32. Registrar's Sinature

Richard A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010^a 12:20 A M Eicholtz Domenica C. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Heart Homes Lutherville Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral Age (In vrs. last birthday) Days June 19 19 19 19 19 19 19 28 1 □ M 2🛣 F Min. 82 Marwrand 214-24-1280 Director 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Baltimore Lutherville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 1420 Frant Avenue Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 2x No 1 Tes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Year or Dates other than "naturent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home 27 is marked other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ D'Antoni Angelina Messina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 11 Springhill Farm Court Cockeysville, Maryland Pam Newland / Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tu 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. Gardens | 12-10-2010 | Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Move L Immediate Cause (Final Physician/ disease or condition Medical resulting in death) D to (or as a consequence of): Examiner bro ussen (n Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should ! 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Hospital 1 ☐ Yes 2 ☑ No Other: 우 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (fleet 23a) (Type, Print)

Registrar

State

6

BMC

32, Registrar

V. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear Physician 2010 5-25AM NOV 06 2 ETT A 10TT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death **Examiner** Baltimore Lutherville Brightwood Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 21 F 93 Sept 16, 1917 224-14-7641 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County ral", or items 23a or 28a-f show Examiner must be notified at 1√PYes 2□No MD Baltimore Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21223 1514 W. Franklin Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: black þ 3 XWidowed 4 ☐ Divorced unk unk Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau 515 Brightfield Road Lutherville, MD 21093 Brightwood Center 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Other(Specify) in state State Affactomy and ard 655 W. Baltimore Street 21. Signature of Fun 115 unice Licens Director Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate wise (Final DENENTIA STAGE END **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Waknown Anemia Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed has 1□ Yes certificate 2 40 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 1 ☐ Yes 2 ☐ No 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours at To the Funeral C

Shakunmala State Registrar

Spepte MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

29b. Signature and title of certifier

frepte Sanhap 9650

and manner stated

DHMH 17 Rev 1/2001

29c. License number

00053150

29d. Date signed (Month, Day, Year)

MP

21045

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryla	and / Depa	artment of I	Health a	and Men	tal Hygi	ene			
			State Registrar		Cer	tificate of I	Death		Reg. No. 2 Ω 1 Ω 2 Ω 6 2 2				
	Dhuniain	/	1. Decedent's Name (First, Middle, La					ate of Death	o. Time of Death				
	Physicia Medic		Gilbert	М •		Fiel	ds		onth Comber	Day 2	Year 2010	17:55 M	
- 6	Examin		4a. Facility Name (if not institution, give	e street and number)		4b. City, Town, o	r Location of			4c. County	of Death		
			Sinai Hospital of 5. Social Security Number 6.3	Baltimore		Balti	nove	City					
	Funeral			V	s. last birthday)	If Under 1 Year Months Days	If Under 2 Hours		ate of Birth	20.5		lace (State or Foreign	
i i	Director		216-36-6395	72	Yrs.	Months Days	Hours	0	Mon <i>th, Day</i> , Yo 13	38	Count	MD	
	d bow It		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Loc	otion							
	ırylar I-f sh ied a	cto	MD NA	100.		imore					110	0d. Inside City Limits	
	r 28g	Dire	10e. Street and Number									1 X Yes 2 □ No	
	ith th	ral				10f. Zip Code	207		10	g. Citizen of W		try?	
	ath w	Funeral Director	2204 Southland	12. Was Decedent Ever in	10 110 1		207	. 0 (0 - : ()			5 . A .		
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once,	þ	1 Never Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	I .	Vas Decedent of H Yes, specify Cuba ☐ Yes 2【 No		nr (Specify Y , Puerto Rican	es or No- , etc.)		- America k, White, e		
5-0	"natu dica	plet	15. Decedent's E (Specify only highest gi	ducation	16a. Deced	ent's Usual Occup	ation		16	6b. Kind of Bu	siness Ind	ustry	
7	nin 7% be. han	E	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	NOT use retired)		or working		Howard Public	d Co	unty	
~ <u>12</u>	ygier bert t, th	Be Completed	9th grade	na	Cu	stodian	1			Public	SC	hools	
20 20	e filed tal H ad ot ever	10 B	17. Father's Name (First, Middle, Last)					•		iden Surname)			
Field	Men Men narke	-	Thomas Fields		r		Rose	tta Cl	nambe:	r s			
Mar	shou rand		19a. Informant's Name/Relationship (1		1	g Address (Street							
7 6	and 2 lealth im 27 her t		<u>Laura Fields-W</u>			Southla	ind Re	oad,	Balti	more,	Md_	21207	
Gilbert Fields Baltimore, Maryland 21215-0036	Page 1 attent of the tant; If ite jury or ot		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	Removal from State	Place of Dispose cemetery, crem	sition (Name of atory or other plac orial F	ark :	12/10	/2010	Wood.	City or Tov Lawn	vn, State • Md	
Baltimore,	permit Depart Impor any in		21. Signature of Funeral Service Licen	see B. Ke	EL 3/1	Name and Addre arch F/ 300 Wak	H We	st Ave,	Balti	more,	Md	21215	
I			23a. Part 1. Enter the list ase, or comshook, or heart fall e. List only of	plications that caused the	ath. Do not ente	r the mode of dyin	g, such as ca	ardiac or resp	iratory arrest,			Approximate	
	Physician/		Immediate Cause (Final disease or condition		- C	. 1					- 5	Interval Between Onset and Death	
actions	Medical		resulting in death)	a. Cerchral Due to (or as a conse	quence of):	7001					- 1	1 days	
F	Examiner	.	On many that the first are selected	Apric	Dissecti	nn					_ _	days	
\sim $-$		Examiner	Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying	Due to (or as a conse		*					170	Aus s	
	outed nd ransi	cam	Cause (Disease or iinjury that initiated events	C									
	exection and initial-t	<u> </u>	resulting in death) Last	Due to (or as a conse	quence of):								
260	te be	edical		l d		·							
87	tifica ng pl	ĕ	F FEMALE:										
Division of Vital Records, P.O. Box 68	tendi		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr	nancy etal death 3 🗌	Ectopic pregnance	y			23d. Date	of deliver	у	
Bo	deat he at ed fc	sic	1 Yes 2 No	4 ☐ Pregnant at time o 9 ☐ Unknown	f death 5	Other (specify)		 .		Month Day Year			
Ö	t the	ᇎ										_	
σ.	s tha gned be de	ا ۾	Part II. Other significant conditions o	ontributing to death but not re	esulting in the un	derlying cause giv	en in Part I.	2	3e. Did tobac	co use contrib	oute to the	cause of death?	
sp	quire sen si suld	ह्	Hypertension					-	1 🗌 Yes	2 □ No 3	Proba	abiy 4 🔼 Unknown	
õ	aw re as be 2 sh	Completed	Peripheral Vascu	dar Disease				2	4a. Was an autopsy	24b. W	ere autops	sy findings available	
ě	The late has bage	<u>`</u> [Prostate cancer					1	performed	d? de	eath?		
<u>a</u>	ian: rtifica xtor,		25. Was case referred to medical examiner?			26. Pla	ace of Death	(Check only o		2410	L 163 2	.e.s. 140	
Ζ̈̈́	ysic direc	2	1 ☐ Yes 2 K No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3 🗆 DOA Othe	r: 4 🗆 Nurs	sing Home 5	Residenc	e 6 🗆 Other	(Specify)		
of	ig Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at			njury occurred		-	
on	eath.	<u> </u>	2 Accident Investigation		injury .		r Yes 2□N	No .					
<u>.is</u>	er de recto by ti	=	3 Suicide 6 Could not b	28e. Place of Injury - At I		et, factory, office	1110		cation (Stree ty or Town, S	t and Number	or Rural F	loute Number,	
Š	rs aft	building, etc. (Speaify)								tate)			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	only one) 3 Certifying Nurs	sician: To the best of my knowner: On the basis of examination of the best of rectioner: To the best of rectioner.	on and/or investio	ation. In my opinio	n, death occu	urred at the tim	ne date and n	lace and due t	o the cause	o(e) and manner stated	
	Marit Con		29b. Signature and title of certifier			29c. License			29d.	Date signed (Month, Da	ay, Year)	
			Motion O.	eardey Do.		15586	88 33	3	0	ecember	a, 2	olo	
V			0. Name and address of person who o	ompleted cause of death (Ite	m 23a) (Type, Pri	nt)	-						
V			Steven Beauch		l West	Belved	lere	Ave,	Balti	more,	Md	21215	
	-	1	1. Date filed (Month, Day, Year)	32. Registrar's Sign	ature								
1	State		DEO 0 0 0010	As A	Man. Sal								
A But	Registra MH 17 Rev 7/200		DEC 0 9 2010	Denva B. 1	garke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per DVR C010 12/09/10 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Franklin 2010 6:53 A M Gary Freed, Sr. November Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 3502 4th Street Brooklyn If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country)
 PA 7. Age (In vrs. last birthday) Funeral 1 **x** M 2 □ F 1 1 - 10 - 1 942 68 Director 218-44-2534 Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ral", or items 23a o Examiner must be Funeral 21225 United States 3502 4th Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ♣ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XXNo Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced permit, Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Port Authority Transporter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Lee Freed Mabel Ellen Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle L. Gawronski - daughter 3502 4th Street, Brooklyn, Maryland 21225 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1xx Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Prk. 12-03-2010 Elkridge, Maryland Sign ture of Funeral Service Live 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ed by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗆 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen MSCULAR DISE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2 autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. INEHKO NOVEMBETT 30. 2018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carlos Palatinghug Brooklyn Medical 3721 Potee ST BAlto MD 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yea 6.51 PM Mark Patrick Gallagher 2010 0 4c. County of Death 4a. Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death 13altiro 000 St. Agnes Hospita 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Days Hours 1 MM 2□ F 212-78-0702 50 1960 Sept. 16, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1808 Colonial Road 21207 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Auto Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Gallagher Dorothy Simkevicius 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Gallagher / Mother 1808 Colonial Rd., Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc | 12/08/2010 | Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signature of Funeral Service Licensee Alyson K Taylor Frederick Rd., Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) (or as a consequence of): not known Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐Yes 2 ☐No 2 No 1 TYes

Division of Vital Records, P.O. Box 68760, والمادية 101 lagher, Mark 24 hours a Hospital within 2 To the I

physician and s the burlal-trans attending p cate has been signed by the page 2 should be detached the funeral director, or Attending Fafter death. filled in by noletely

Physician

/Medical

Examiner

Funeral

Director

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Certification: To

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State Registrar 27

29a. Certifier

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

. Was case referred to med	lical	26. Place of Death (Check only one)								
examiner? 1 ☐ Yes 2 ☐ No	Hospita	al: 1⊿Inpatient 2□	2 ER/Outpatient		OOA Other: 4 🗆	Nursing Ho	me 5 ☐ Residence 6 ☐ Other (Specify)			
Z L. Accident	nding estigation	a. Date of Injury (Month, Day, Year)	28b. Time of Injury	м	28c. Injury at Work? 1 □ Yes 2	! □No	28d. Describe how injury occurred			
	uld not be ermined 28e	e. Place of Injury - At h building, etc. <i>(Spe</i> c	nome, farm, stree	t, facto	ry, office		28f. Location (Street and Number or Rural Route Number City or Town, State)			

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

P24057

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Curio Datoes 1, 900 S conton Ave Baltimore, MD 21229

31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mae Gompf Dec. Regina 2010 9:45 ΑМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Baltimore Timonium Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Months Days Hours Min. 1 ☐ M 2 🔀 F Director 217-18-8990 86 Marvland Usual Residence of Decedent artment of Heath and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits Baltimore Glen Arm 1 🗆 Yes 2 🔯 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4113 Halifax Court 21057 United States Was Decede... Armed Forces? Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within i Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the term Elementary/Seconday (0-12) College (1-4 or 5+) Data Processing Baltimore County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Samuel E. Harper Marjorie C. Fleagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ron Gompf / Son 4113 Halifax Ct., Glen Arm, MD 21057 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/10/2010 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Rd. Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause op-each line. Immediate Cause (Final 0 Ph sician/ disease or condition resulting in death) 9 60 Months Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner Due to (or as a nonsequence or; if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No Pregnant at time of death
Unknown 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: ည 1 🗌 Yes 2 2 No 4X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760

A.M.

completed filled in by the within 24 hours a To the Funeral E

Medical

29a. Certifier

(Check only one

29b. Signature and title of certifier

31. Date filed (Month, Day,

westing

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

ERNESTINE WRIGHT, M.D.32 Registrar's Signatur 2010 arks

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed, (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** MARSHA CIREEN 0408AM N. DELEMBER 06 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE BAYVIEW MEDICAL CENTER HOPLINS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2**X**□ F 52 Yrs. Director MD 07-19-1958 220-68-1115 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at MD DUNDALK 1XYes 2 □ No Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number death with 7213 DUNGLEN CT. 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 XNo , o. Maryland 21215-0036 1 ☐ Yes 2 No Specify. BLACK Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 ASSEMBLY WORKER CCLR, INC marked other Department of Health and Mental Hy Important: If Item 27 is marked otherwish in Jury or other *** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GREEN ၉ WILEARN MILDRED SPARKS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIKESHA TRENT/DAUGHTER 2812 HAMILTON AVE., BALTIMORE, MD 21214 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MEADOW RIDGE 12/14/10 ELKRIDGE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A.MORTON & SONS F.H., INC ames 1. 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death US Minutes Immediate Cause (Final **Physician** PULMONARY Emborism disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 🗷 No Month Day Year 5 Other (specify) detached Ö 9 HInknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☐ No of Vital 1 ☐ Yes 2 🗷 No director 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 29a, Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 DECEMBER 06 2010 JORDAN SAX MD 1830 EAST MENUMENT STREET 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 6-100 BALTIMORE, MD JOHNS HOPLINS DEPARTMENT OF EMERGENIN SAX MEDICINE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

D. parl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar		S	State of	Maryla	and / I	Depart <i>Certif</i>				and M	lental Hy	/gien Reg. N	20	10	3	8627
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Baltimore, Maryland 21215-0036 sermit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam page. To Be Completed by		1 😾 Burial 2 4 □ Donation	Cremation	3 ☐ Ren pecify)	noval from S	tate	cemete	ry, cremato	ory or ot	her plac			/2010	1		-		ite
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Division of Vital Records, talor Attending Physician: The law requires rs after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be the Certificate: To Be Completed Is		Accident 3 Suicide 4 Homicide	Investig 6 Could determ	gation not be	28e. Place o			ırm, street,	M factory,		Yes 2		28f. Location	(Street a	and Numb	er or Rura	l Route	Number,
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SOSEPH 2010 1700 P M Nov 30 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) Washington, DC 7. Age (In vrs. last birthday) **Funeral** 1**x** M 2 □ F Months Days Hours Min Yrs **Director** 577-50-3329 Usual Residence of Deceden 28a-f show 10a. State 10b. County with the Maryland aţ 10c. City, Town or Location 10d. Inside City Limits Director notified Yes 2 ☐ No MD Calvert Dowell 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 530 Summerset Court 20629 within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Painter Self Employed is marked other Be Page 1 and 2 should be filed ment of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene P Goodall Marion Coleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Rita D. Goodall (wife) 530 Summerset Ct. Dowell, MD. 20629 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-07-10 Lincoln Cem. $\operatorname{Brentwood}$. Signature of Funeral Service Licensee 22. Name and Address of Facility 20019 Dunn & Son Funeral Home 5635 Eads St NEWash DO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ ASCVD disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy performed? death? certificate 1 ☐ Yes 2 😾 No 1 ☐ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 2x No Certificate: To 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural (Month, Day, Year) 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after death Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

Holy Cross Hospital, 1500 Forest Glen Rd, Silver Spring, MD 20910-1484

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D 64296

NOVEMBER. 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G911 1/07/2011 IH State of Maryland Department of Health and Mental Hygiene For State Registrar 38629 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Otto J. Gusella Physician/ Month Day December Day Year 0400 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death Examiner 4c. County of Death Shadubrove Adventist Hospital Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 5. Social Security Number
548-54-8127 1 XM 2 □ F Min Month: 76 Yrs Director /16/1934 Canada Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Montgomery Germantown 1 XYes 2 No ò 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be 17500 Charity Lane 20874 Funeral USA within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Director Telecommunications is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental 6 Otto John Gusella Wat Page 1 and 2 should be ment of Health and Menta Christina Watson McMahon 19a. Informant's Name/Relationship (Type, Print) Marlene J. Gusella / Wife 27 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2xxxremation 3 ☐ Removal from State Final Journey Crem. 12/9/2010 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Borota Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction minute disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Diabetes years Sequentially list conditions, Examine Due to for as a consequence of it any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Felai Go 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires I within 24 hours after death.

To the Funeral Director: After this partitional hours. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 No 1 Yes 2 No Yes Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2.2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D 36979 December 5,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deborah 5. Sherrill MD 9901 medical Ctr Dr. Rockville, MD 20850 3. vill 31. Date filed (Month, Day, 9 2010 32. Registrar's Sig lature State ack Registrar

2040

13/5/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2010 $\mathbf{P}^{\,\mathsf{M}}$ 2:55 Dora Maria Galliani Medical a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death La Familia Assisted Living Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea **January 26,** Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Yrs. **Director** 220-42-0745 86 Peru Usual Residence of Decedent or 28a-f sho notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Gaithersburg 1X Yes 2 ☐ No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a o Funeral 449 Lynette Street 20878 United States ural", or items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1ऍYes 2□No SpecifyPeruvian If Yes, Give Year or Dates. Specify: White Completed 3 X Widowed 4 Divorced "natural" other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 International Banking Executive Secretary Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hector Vivanco Marie A. Sanchez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 449 Lynette Street, Gaithersburg, Maryland 20878 <u>Joe Galliani/Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium. Inc. 20a. Method of Disposition 20c. Location - City or Town, State December 10 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2010 Bethesda, Maryland 21. Signature of Funeral Service House M. C Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Ave., Rockville, MD 20850 Chawlan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Alzheimer's Disease Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Pregnant at time of death 5 Other (specify) Month Dav Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 X No ျှ 1 🔲 Yes 4 Nursing Home 5 Residence 6 Dther (Specify) Group Home 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural Accident 5 Pending 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D27660 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alpana Goswami, MD 11125 Rockville Pike, #110, Rockville, Maryland 20852 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

CALLIAN

DORA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 30. Charles Giro 2010 James 10:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex . Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. 1**x**x M 2 □ F Hours 05-18-1949 218-52-2353 Director 61 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No MD Howard Ellicott City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 4588 Roundhill Road 21043 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Force Black White etc. 1 Never Married 2 Married 2X X No ☐ Yes Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2xxx No Specify: Specify: 3 X Widowed 4 □ Divorced White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Railroad Ith and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary F. Harold Charles Joseph Giro 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is 1 any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1633 Beason Street, Baltimore, Maryland 21230 Nicholas C. Giro -Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Meadowridge Mem Park 12-06-2010 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Signature of Funeral Service Line 10. MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for seis consequence of: MS. attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a 9 | Unknown 9 Unknown P.0. ert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed to should be det 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed?

1 Yes No 1 Yes 2 No Division of Vital To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2**X** No Other: 1 Inpatient 2 ER/Outpatient 3 DQA 4 Nursing Home 5 Residence 6X Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital or A 24 hours after Funeral Direct after Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the within 2 To the title of certi 80071287

DHMH 17 Rev 7/2009

Registrar

10

St. Suite 4105, Baltimore, No 21204

of person who completed cause of death (Item 23a) (Type, Print)

00 VA

9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Cameron Tucker Hallameyer 01:30 AM Dec. 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 107 Hampshire Road <u>Baltimore</u> 5. Social Security Numbe If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Feb. 20, 2003 Months Hours Min 1**y** M 2 □ F 219-65-7100 **Director** MD Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Directo Examiner must be notified MD Baltimore Essex 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Hampshire Road 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: Specify: White Completed 3 UVidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) n/a 1 yr 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joshua L. Hallameyer Kelly M. Wangelin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua Hallameyer /father 107 Hampshire Road Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place; 1 KBurial 2 Cremation 3 Removal from State OAk Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 12/10/10 Baltimore MD 21. Signature / f Funera Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that cabeed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ ependy moma disease or condition 6 years 5 mintes Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (visease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Cther (specify) in the past 12 months? Pregnant at time of death Month Year Day 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ from suchlowing dysfunction 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔊 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending iours after death.

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filled in by the fu 1 🔲 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 2 Medical Examiner: On the basis or examination allows investigation, acting spanish, weak to be added to the cause (s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause (s) and manner as stated within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/2010 DO061568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Christopher J. Gamps

600_N

wolfe St. LASC 800

Bullmore MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / [Department of Certificate of			2010	38633		
		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of	Dealli	2. Date of Death	eg. No O	1		
Physic		Rachael Hurst			Month Decembe	Day Year	3. Time of Death 12:15 A ^M		
Med Exam		4a. Facility Name (if not institution, give street and number)	4b. City, Town,	or Location of Death	1	4c. County of Dea			
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Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 ≥ 1 ≤ 1 ≤ 1 ≤ 1 ≤ 1 ≤ 1 ≤ 1 ≤ 1 ≤ 1 ≤	Months Dave		8. Date of Birth (Month, Day, June 26	9. Bir Year) Co	rthplace (State or Foreign ountry) PA		
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yland -f shc ed at	[향	10a. State 10b. County 10c. City, Town					10d. Inside City Limits		
e Mar r 28a notifi	j.	Maryland Anne Arundel		len Burni			1 Yes 2 X No		
with th s 23a o ust be	Funeral Director	321 Delaware Avenue	10f. Zip Code	21060	1	10g. Citizen of What Country? USA			
death item:	匝	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I	Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No-	14. Race - Ame			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 Never Married 2 Married 1 Tyes 2 No	1 Yes 2 X N		Thom, co.,	Black, Whit	_{te, etc.} White		
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Tand be filed fental Hy rked oth	10 E	17. Father's Name (First, Middle, Last) Arthur Johnston		18. Mother's Nam Sally	ne (First, Middle, M Fry	aiden Sumame)			
should and M is ma		19a. Informant's Name/Relationship (Type, Print) 19b	. Mailing Address (Street	t and Number or Run	al Route Number, (City or Town, State, Zi	ip Code)		
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ge 1 age 1		1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State	Disposition (Name of y, crematory or other pla	ace) Dec	. 09 I	20c. Location - City or			
Dealtillor Dermit. Page 1 Department of mportant: If is any injury or consider.	51	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ucep∮ee	g Hill Ceme	- 1 2	010	Shippensbu			
Departing Important		Musshelf Stalling	N.			ings Funer asadena, M	al Home, P.A. D 21122		
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ysicia nysicia nis cer direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	Total	her:		nce 6 🗆 Other (Spec	cify)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi		The trade of the t	ijury wor	iry at	28d. Describe hov		,		
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e Hosp 24 ho e Fune	Medical	29a. Certifier (Check only one) 1 Mertifying Physician: To the best of my knowledge, c 2 Medical Examiner: On the basis of examination and/or 3 Certifying Nurse Practifying Ty the best of my knowledge.	r investigation, in my opin	ion, death occurred at	t the time, date and	place, and due to the	cause(s) and manner stated.		
To th		29b. Signature and titls) of certifier	29c. Licens			d. Date signed (Monta			
1		30. Name and address of person who completed cause of death (Item 23a) (I	I/De Print\	20017		12/08	710		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ Month Day Year HETTCHEN HENRY 8-40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death **Howard County General Hospital** Columbia Howard Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 1 M 2 D F 217-22-9876 83 Director 28 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Howard **Ellicott City** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral 8417 Elko Dr. 21043 U.S.A. 12. Was Decedent Ever in U.S.

Armed Forces?

7/30/1946
If Yes, Give

1/21/1948 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 → Widowed 4 □ Divorced 1/21/1948 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) electrical technician electricity Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Hettchen Edna M. Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Hetchenn 8417 Elko Dr. Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place)
Parkwood Cemetery Dec 10, 2010 Baltimore, MD 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 an relof Funeral Se ve Lice 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician: SEPSIS disease or condition FW 0441 Medical resulting in death) Due to (or as a consequence of): Examiner PN EUMONIA FEW DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlansit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🗷 Natural 5 Pending injury 2 Accident
3 Suistal 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for my promote the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated for my promote the control of the time, date and place, and due to the cause(s) and manner stated for my promote the control of the time, date and place, and due to the cause(s) and manner stated for my promote the control of the 29b. Signature and title of certifiel 29c. License number MD D0062634 DEC 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATEEN 10796 AWAN COL UMBIA 141CK624 RIDGE RD 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_1	State Registrar		Cei	tificate of E	Death	F	leg. No.		
			1. Decedent's Name (First, Middle, Las	11				Date of Dear Month	th Day	Year	3. Time of Death
	Physicia Medic	al	Janes 1	. Home				12	6 9	Ulu	10:120M
	Examin		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Death		4c. County		oward
1				ton Woods Wa		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			place (State or Foreign
	Funeral	5	5. Social Security Number 6. Social Security Number 1	X M 2 □ F 7. Age (II	n yrs. last birthday) 64 Yrs.	Months Days	Hours Min.	(Month Day	Year) 22, 1945	Cour	
	Director	-	Usual Residence of Decedent		04			Dec	22, 1343		
	nd how at	. r	10a. State 10b. County	11	Oc. City, Town or Lo	cation					10d. Inside City Limits
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Maryland	be filed lental Hy rked oth	[윤	,	Milo Wayne Ho	pper			Vera	a Patrica I	Katiga	n
<u>Z</u>	12 should I Ilth and Me 27 is marl r traumati		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mail	ng Address (Street	and Number or Rur	al Route Number	City or Town,	State, Zip	Code)
	12 shallth al 27 is rtrau		Ok Sun Hopper Spo	ouse	95	16 Thornton	Woods Way	Columbia	, MD 2104	6	
ē,	of Heal of Heal fitem ?		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	ce)	Date	20c. Location	- City or T	own, State
e E	Page nent o ant: If ury or		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			National Cem		b 24, 2011		Arling	gton, VA
altimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	1	21. Signature of Funeral	see D	2	2. Name and Addre	ss of Facility Funeral Home,	DΔ			
m	e a = E e		Villoditach	er Dhoht!	401693	3871 O	ld Columbia F	ike Ellicott		043	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the cause on each line.	ne death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between
-6	nysician/		Immediate Cause (Final disease or condition	1	NOW Q	1	ease				Onset and Death
e d	Medical		resulting in death)	Due to (or as a c			1 1				
	Examiner	<u>.</u>	Sequentially list conditions,	b. Chron	onsequence of):	tructure	lung of	Wear t		-	444
	p #	Examiner	if any, leading to immediate cause. Enter Underlying		VC3						
	and trans	xan	Cause (Disease or linjury that initiated events c. Due to (or as a consequence of):								7,,
_	oe exe ician burial		Toodking in a sally 225	. Asc a	e1 / 60	terdeni					VII
38760	phys the I	Medical		d							
89	ertific iding se as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy				23d. D	ate of deli	very
ŏ	atter atter for u	Physician	in the past 12 months? 1 Yes 2 No	4 💹 Pregnant at t	Fetal death 3 ime of death 5	☐ Ectopic pregnan ☐ Other (specify) _	icy		М	onth	Day Year
P.O. Box	he de y the iched	hys	g 🗌 Unknown	9 ∐ Unknown							
P.O	that the		Part II. Other significant conditions	contributing to death but	1	1	iven in Part I.				the cause of death?
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Orc	w req s bee	Completed by	by ventrule	s tacky	cardia.	had de	fibrillet	24a. Was		prior to c	opsy findings available completion of cause of
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alF	an: T	Be C	25. Was case referred to medical examiner?				Place of Death (Che	ck only one)	(A)		
ξ	nysical is ce direct	<u>P</u>	1 ☐ Yes 2 No		t 2 ER/Outpati	ent 3 🗆 DOA		lome 5 Resid			fy)
of	ng Pl		27, Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day,	Year) 28b. Time injury	wor	rk?	28d. Describe h	ow injury occur	red	
ion	tendi death tor: A the fu	iji	2 Accident Investigation 3 Suicide 6 Could not	ho .	/ - At home, farm, s		Yes 2 No	29f Location (9	Street and Num	her or Rut	al Route Number,
Division of Vital Records,	or At after d Direct in by	Certificate:	4 Homicide determined	building, etc.		ileet, factory, office		City or Tow	n, State)	50, 0, 7,0,	-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	cal	29a. Certifier 1 Certifying Ph	ysician: To the best of m	y knowledge, death	occured at the tim	e, date and place, a	and due to the ca	use(s) and man	ner as sta	ted.
	e Hos n 24 h e Fur sleted	Medical	(Chook 2 Medical Ever	niner: On the basis of exa rse Practioner: To the be	mination and/or inve	stigation, in my opin	ion, death occurred	at the time, date a	and place, and d	ue to the c	:ause(s) and manner stated.
	To th withir To th comp	-	29b. Signature and title of certifler	N N		29c, Licens	se number		29d. Date sign	ed (Month	, Day, Year)
			Church	J. Maur	40	D	969696	4	12		1-9010
,	7		30. Name and address of person who			Print)	lac T	deil RJ	(1	h 1	MJ DIUY6
1			Christine	A Marino		0320 7	teren, to	sterl 120	COIM	DIE	21070
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	s signature						

Box 68760

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of 3. Time of Death Physician/ Day 2 E) M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Harwood Mandrin Hospice House Social Security Number If Under 1 Year If Under 24 Hrs. Funeral . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min Hours Year 925 1 M 2 July 6 EngTand Director 85 578-42-3006 Usual Residence of Decedent or 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Prince George's Suitland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20776 3675 Solomons Island Road death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Healith and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin any injury or other traumatic event, the Medical Examin 1 Never Married 2 Married ≥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home 12 homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Josephine Wytham John William Hayter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip. Code) 8281 Armetale Lane Fairfax Station, VA 22039 Joanne Owens/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service State and Address W. Baltimore Street 21201 Baltimore. MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Approximate** Interval Between and Death Immediate Cause (Final Physician/ HRONI disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ctopic pregnancy
5 Other (specify) ate has been signed by the atte page 2 should be detached for Pregnant at time of death
Unknown Month 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 No 3 Probably 4 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2: No of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 100 Other: ဂ္ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Division 1 Yes 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 010 completed cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar

State

filed (Month, Day, Year)
DEC 0 9 2010

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Division of Vital Records, P.O. Box 68760, 24 hours a within 2 To the I

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. John Yottavathil 9000 Franklin Square Drive Baltimore MD 21237

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

DECEMBER, 4,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12/7 Physician/ Charles H. Klaus, Sr. /2010 10:55 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3515-1/2 Meadowside Rd Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth Funeral 9. Birthplace (State or Foreign 1 **X** M 2 □ F Months Min. Hours 371071914 Country) 214-12-2135 96 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 230 cm any injury or other traumatic event, the Marker and injury or other event. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3515-1/2 Meadowside Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces's Black, White, etc. þ 1 \square Never Married 2 \square Married X Yes 2 □ No 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. unknown Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5 Stationary Engineer Seagram Distillery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John William Klaus, Sr. Katherine Ahring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn A. Klaus/Daughter 136 The Maine, Williamsburg, VA 23185 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 12/11/2010 Woodlawn, MD 21. Signature of Funeral Service Licensee ቼኒኒፕሮያያ ሲያያር ይመመር የተመሰው ያለ Erematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a Part f. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Carebrel vescul Medical Due to (or as a consequence of) Examiner Sch-Sequentially list conditions, if any local cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be execu within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year sate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ Completed Ostro my 1-t-s 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an MRSA intachion autopsy performed? Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatus

31. Date filed (Month, Day, Year)
DEC 0 9 2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

14 Per FH C911 1/06/2011 JH
State of Maryland / Department of Health and Mental Hygiene 2 | | | For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Judy Kerr 7:15 A M 24 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Capitol Heights 9412 Hickory Park Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 02/25/1951 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Min. 59 Months Hours 1 M 2 😾 F Michigan Director 365-54**-**7469 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Modical 10c. City, Town or Location 10a. State 10b. County Director Capitol Heights 1X Yes 2 No MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 20743 9412 Hickory Park Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 😿 No Completed by Baltimore, Maryland 21215-0036 White Specify: Black 1 ☐ Yes 2x No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Staffing Coordinator 2 vears Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Myrtle Gray Robert Eugene Kerr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9412 Hickory Park Street Capitol Heights, MD 20743 LaTonya Kerr/Daughter 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Clinton, MD 12/06/2010 Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licensee 4308 Suitland Road Suitland, MD 20746 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death I Week Immediate Cause (Final Physician/ Acute Stroke disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension years Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury Diabetes Mellitus 5 years that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No

9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 1 ☐ Yes 2xxx No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only o 29b. Signa ure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/03/2010 D24535 ク 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berwa 7700 Old Branch Avenue Clinton, MD 20735

State

Registrar

31. Date filed (Month, Day, Year,

09

ack

32. Registrar's Signature

Physicia		- For State Amend Item 17 per fh , g970, 1271 Registrar 1. Decedent's Name (First, Middle, Last) Kurt Alan Koslock		Reg	g. No. 3. Time of Death							
Medical Exami		1. Decedent's Name (First, Middle,Last) Kurt Alan Koslosk Kurt Alan Koslosk	sloski	Month December	Day Year 1110 hrs							
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2713 E. Northern Parkway 5 Social										
Funeral Director		5. Social Security Number 165 46 65 43 213-82-6543 1 M 2 F	**	Min. 04/10/	7 (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD							
Mand any show any ace.	7	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Baltimore		10d. Inside City Limit							
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 2713 East Northern Parkway	10f. Zip Code 21214	104	g. Citizen of What Country? USA							
21215-0036 Uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she ie event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armed Forces? 1 X Yes 2 No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu Yes 2 No specify:		14. Race - American Indian, Black, White, etc. Specify: White							
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Exami	Completed b		edent's Usual Dccupation (Give kind ng most of working life. DO NOT use Disabled		16b. Kind of Business/Industry N / A							
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	Be	17. Father's Name (First, Middle, Last) Joseph Koslowski Koslosky	Kreuzer									
MD id 2 shoulth and 27 is summer!	၉	Iris M. Roggio / Mother 27		n Pkwy.,	Baltimore, MD							
Baltimore, MD 2 pemit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumartie		1 Burial 2 XX remation 3 Removal from State Final	sposition (Name of cemetery, or other place) Journey Crem. 1		20c. Location - City or Town, State Woodbine, MD							
		21. Signature of Funeral Service Licensee Dorota Marshall Luca Caracter Dorota Marshall 23a. Part I. Enter the disease, or complications that caused the death. Do not er	22. Name and Address of Facility Maryland Cre PO Box 1413	emation S Baltimo	Services ore, MD 21203 st, shock, or heart Approximate Interva							
Physician /Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined Drug(Alport or condition resulting in death) Due to (or as a consequence of):			Between Onset and							
٨	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
760, icate be executed physician and the burial - transit	lical Ex	d. **EUNPENDED ** AMENDED ** 23a, 27, 28a-f per me g913 3-10-11 vt **Ipen**F.G910.12/14/10.WS **Ipen**F.G910.12/14/14/10.WS **Ipen**F.G910.12/14/14/10.WS **Ipen**F.G910.12/14/14/10.WS **Ipen**F.G910.12/14/14/10.WS **Ipen**F.G910.12/14/14/10.WS **Ipen**F.G910.12/14/14/14/14/14/14/14/14/14/14/14/14/14/										
ox 68 eath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown										
i, P.O. E ires that the d signed by the detached	<u>る</u>	Part II. Other significant conditions contributing to death but not resulting in	acco use contribute to the cause of death? 2 No 3 Probably 4 Unknown									
Records, The law requir ate has been s	Completed			24a. Was ar autopsy perform 1 Yes 2	prior to completion of cause of death?							
tal Resign: The	Bec	25. Was case referred to medical examiner?	26.Place of Death (Che									
ion of Vital Recteodiog Physician: The leath. The There this certificate the funeral director, page	유	1 Yes 2 No lospital 1 Inpatient 2 ER/Outpa 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time	tient 3 DOA Other Nu e of Injury 28c. Injury at Work?		esidence 6 Other Scene							
ion teath.	읥	Natural 5 Dending	:00am 1 Yes 2 X No	unknown								
Divis Hospital or At 24 hours after d Fuoeral Direct tely filled in by	Certification:	3 Suicide 6 X Could not be determined (Specify) residenc	e	or Town, Sta	reet and Number or Rural Route Number, City tte) 2713 E. Northern P							
To the Ho within 24 h To the Fu completely	Medical	(Check only 2 Medical Examiner: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated.										
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo. December 3, 200)											
2xperd		30. Name and address of person who complete value of deam (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examine	r 111 Penn Street, Baltim	nore, MD 21201								
St. Regist	ate	31. Date filed (Month, Day, Year) DEC 0 9 2010 32. Resistrar's Signature										
DHMH 17 Rev 1/20		ORIG	NAI									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 1029 AM **Physician** 2010 MAE vovember KIMBALI /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MORE TOSPITAL ARBOR 6. Sex Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 5. Social Security Number **Funeral** Min. 1 ☐ M 2 🛱 F Yrs Maryland Maryland Nov 21, Director infant Usual Residence of Decedent 10d. Inside City Limits e filed within 72 hours after death with the Maryland at Hygiene.
I other then "natural", or Iteme 23a or 28a-f show vent, the Medical Examiner must be confilled at 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2√ No Completed by Funeral Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 USA 1709 Kimber Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be life Department of Heelth and Mental Hy Important: If Item 27 is marked othing any july or other traumatic event, SIDE. 17. Father's Name (First, Middle, Last) Be Danielle Ragan John Michael Kimball ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3001 S. Hanover Street Baltimore, MD Harbor Hospital Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in/state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signative of Fun ral S. V. Licensee Director Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine es the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physicien d be detached for use es the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Pالميو Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate has 1 Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3□ DQA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 2 🗌 No 1 TYes investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S HANGVER STREET, BALLO, MD 21225 31. Date filed (Month, Day, Year)
DEC 0 9 2010 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Maryla	,	artment of <i>rtificate of</i>		and Me		ene g. No:	0	386	43
	Dhi.i		1. Decedent's Name (First, Middle, Last)						2. Date of Death Month	Day	Year	3. Time o	f Death
	Physici /Medic		Marion P. Krac	ke		,		1	November	24, 2	010	5:45	AM M
)	Examin	er	4a. Facility Name (If not institution, give :		,	4b. City, Town,		of Death		4c. County			
			Presbyterian H 5. Social Security Number 6. Sec		and s. last birthday)	Towso		24 Hrs	9 Date of Birth	Balti		/C4-40	
	Funeral Director		312-14-7624	IM OFFIC	92 Yrs.	Months Days		Min.	8. Date of Birth (Month, Day, July 7m	1918	Counti	ice (State or y) inois	or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					10	d. Inside C	ity Limits
	Mary -f sh	to	MD Harfor	rd	Re	l Air						1 🗌 Yes	2√□ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of W	/hat Count	ry?	
	th wit	aiD	211 Patterson Mil	ll Road			2101	5		J	JSA		
	ems	Funerai	11. Marital Status	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Orig	gin? (Spec	ify Yes or No-		- America k, White, e		
36	or It	by Fu	1 Never Married 2 Married 3 ▼Widowed 4 Divorced	1 ☐ Yes 2 🖾 No If Yes, Give		1 ☐ Yes 2√2 No					whit		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show than "natural" or Items Items Indifficated		15. Decedent's Edu	Year or Dates:	162 Doop	dent's Usual Occi	ination		1.	6b. Kind of Bu			
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212	s with	E o	Elementary/Secondary (0-12)	College (1-4or 5+)	hou	sewife				own h	ome		
פַ	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, Ite Medical Exama me matter event.	Bec	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name ((First, Middle, M				
Maryland	should be ind Mental ind Merked o	To	Louis D. Peik					Lucy	Bertke				
a	es 1 and 2 should bot Health and Ment i item 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Ty			ng Address (Stree					State, Zip (Code)	
	1 and 1 Health Iem 27 other tr		Jean Close/daught			St. Franc	cis Roa						
altimore,	Pag ent nt: I		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 4 ☼ Donation 5 □ Other (Specify)	1	cemetery, cre	osition (Name of matory or other pla	ace)	Da	ite 2	Oc. Location -	City or Tow	n, State	
Balt	permit. Departm Importar any inju		21. Sign vors of Euneral Septice Licens	he Virecto		2. Name and Addr tate Anal	_		655 W.	Baltimo	re St	reet	
	Physician /Medical		23a. Paul . Enter the disease, or commission, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the dene cause on each line. A C Due to (or as a cons	eath. Do not en		ing, such as	cardiac or		st,		Approximate Interval Bet Onset and	tween Death
	Examiner		Sequentially list conditions.).									
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons-	equence of):								
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687	ficate physics the b												
.О. Вох	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown		23d. Date of delivery Month Day				Year			
<u>a.</u>	that the by detail	/ Ph	Part II. Other significant conditions con	ntributing to death but not r	esulting in the u	nderlying cause g	iven in Part I.		23e. Did toba	acco use contri	bute to the	cause of o	death?
Records,	w requires that been signed b should be deta	d by	Denerton						1 🗌 Yes	2 No	3 🗌 Proba	bły 4 □l	Jnknown
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	The taw te has age 2 :	mo							autopsy	ed? d	rior to com eath?	pletion of a	ause of
<u>ra</u>		0	25. Was case referred to medical				26. Place	of Death	1 ☐ Yes 2; (Check only one		L 165 2	40	
<u>></u>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2∰ No	lospital: 1 Inpatient 2	☐ ER/Outpaties	nt 3 DOA			e 5 🗆 Resider		r (Specify)		
Division of Vital	nding Phith, this structure of tuneral in		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	ury at ork? □Yes 2 □1		3d. Describe how	v injury occurre	ed		
Divis	I or Attendi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	OB Class of Injury At home form that I have the							or or Rural	Route Num	nber,
	To the Hospital or Attending Physicien: within 24 hours atter death: To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physical Control one) 1 Certifying Physical Examination (Check only one)	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the t vestigation, in my	time, date and opinion, deat	d place, an	nd due to the car d at the time, da	use(s) and mar te and place, a	nner as sta nd due to t	ted. he cause(s	5)
	To th within To th sompl	Me	29b. Signature and title of certifier				nse number	. /		d. Date signed			
			1	· MD			1370	16	1	Jovense	2020	1,20	10
			30. Name and address of person who co	empleted cause of death (It	em 23a) (Type, 701 N. (,	
	Sta Registr		31. Date filed (Month Pay Year)	32. Registras Sig	parke	,		·					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) OF CENBER 4 **Physician** 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner LUMB If Under 24 Hrs OL 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** 1 □ M 2 X F Months Days Hours land none 0 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at MD **Baltimore Owings Mills** 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ö 9862 Sherwood Farm 21117 U.S.A. itеms 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 ☐ Married 'natural", or 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked any injury or come. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tarundeep Singh Kalra Archana Jolly ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tarundeep Kalra 9862 Sherwood Farm Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec 07, 2010 Atlantic Crematory, LLC Glen Burnie, MD 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

The law requires that the death certificate be executed

attending pl

has.

this certificate

Box 68760,

P.0.

Division of Vital Records,

the Hospital or Attending Physician:

death. heral Director: A

after

n 24 hours a

within 2 To the

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death 23a. Part 1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallere. List only one cause on each line. 3mg in Compete
Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery Month Day Year

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown þ Completed 25. Was case referred to medical examiner? Be Hospital: 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 5 Pendina investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Sulcide

4 ☐ Homicide

asmir

29a. Certifier

ture of Funeral Service Vicenses

3 Ectopic pregnancy 5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 No 2 No 1 ☐ Yes

26. Place of Death (Check only one) Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated 29b. Signature and title of certifier

determined

29c. License number D0062402 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Holsey

Columbia MD 21044 MD, 10710 Charter Drive

State Registrar

Medical

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

State of Maryland / Department of Health and Mental Hygiefie For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 2:00 AM **Physician** November 10 2010 John Laursen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Future Care Northpoint | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr 5, 1937 9. Birthplace (State or Foreign Country)
Denmark 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1√M 2□F 73 218-42-9684 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director Dunda1k Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 USA 21222 3701 North Point Road #62 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If tiem 27 le marked other the eny Injury or other traumatic event, Ltd. once. construction truck driver unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) KAtie Dondil Anker Laursen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3701 North Point Road #62 Dundalk, MD 21222 Ethel Laursen/former spouse Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of meral Se ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lest only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Pinal disease or condition resulting in death) Stage = nd **Physician** Liver /Medical Due to (or as a consequence of): **Examiner** Socientially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 12 No this certificate : After this certific s funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပို 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 51051 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ligon Rd, Ellicott city, MD 21042 362 zar 31. Date filed (Month, Day, Year)
DEC 0 9 2010 32. Registrate Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:00 PM December 2010 G. LaRoche Mary Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4h. City. Town, or Location of Death Examiner 8213 Moorland Lane Bethesda Montgomery 8. Date of Birth (Month, Day, Yea January 27, 9. Birthplace (State or Foreign Country) New York If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) **Funeral** 65 101-34-2965 "1945 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Ħ Director ral", or items 23a or 28a-f s Examiner must be notified 1 🗆 Yes 2 🗶 No Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 8213 Moorland Lane 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Information Technology Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Security Senior Engineer other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H Donoghue Elizabeth Henry Bicker Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Maryland 20817 8213 Moorland Lane, Bethesda, David R. LaRoche/ Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State December 2010 4 Donation 5 Other (Specify) Bethesda, Maryland Montgomery Crematorium 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 12 M01596 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Pnysician/ Ovarian Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of death certificate be executed tran and Due to (or as a consequence of): resulting in death) Last physician a the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Yea Pregnant at time of death 1 Yes 2 X the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 2 Accider
3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Signature and title 29c. License number D54378 December 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2730 University Blvd. W400, Wheaton, Maryland 20902 Cheryl A. Aylesworth M.D. 31. Date filed (Month, Day, Year) State DEC 0 9 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Day Physician/ 2010 9:56 P M Lowenthal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital 8. Date of Birth
(Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** Min. Days Hours 1 □ M 2 🖾 F Months 127-30-5587 1938 72 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Marken. 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2 🔀 No Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7710 Woodmont Avenue # 1104 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home 5+ <u>Homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shiffman Luba Harry Gross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7710 Woodmont Avenue # 1104 Bethesda, Maryland 20814 Malcolm Lowenthal/ Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of December 9, cemetery, crematory or other place)
Garden Of
Remembrance Cemeter 1 X Burial 2 Cremation 3 Removal from State 2010 Clarksburg, Maryland 4 Donation 5 Other (Specify) Cemetery 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Bethesda-ChevyChase,Inc 7557 Wisconsin Avenue Bethesda, Maryland 20814 Signature of Tuneral Service Ligense MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Perforated Diverticulitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) ned by the attending physician and detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicia. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Yes 2 X No been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s 2 🗌 No 1 Tes Yes 2 X N 26. Place of Death (Check only one) funeral director, Be 25. Was case referred to medical Other: 2 🔀 No 1 X Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Tyes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending X Natura 1 Yes 2 No owen that M Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the l only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License numbe D26259 12/7/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Ava Kaufman, M.D.

31. Date filed (Month, Day, Year)

DEC 0 9 201

2. Registrar's Signature

8218 Wisconsin Avenue Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Ma	ryland / Depa <i>Cer</i>	artment of H			ene	3861.8
	Physici /Medic		1. Decedent's Name (First, Middle, Last) William	Lo	yd		2. Date of Death Month December	Day Year 201	
)	Examir		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Baltimore	Location of Death		4c. County of Deat	h
	Funeral Director			(In yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye Jan. 7,	ear) Cou	hplace (State or Foreign untry)
	yland how at		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	he Mar 28a-fsl otified	Director	MD n/a	Balti					1 ☐ Yes 2 ☐ No X
	3a or 3	al Dir	10e. Street and Number 2713 Beryl Ave.		10f. Zip-Code 212	205		j. Citizen of What Co USA	untry?
36	De lied within 72 nours after death with the Maryland tal Hygiene. tal Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give X Year or Dates:	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	ispanic Origin? (Span, Mexican, Puerto		14. Race - Amer Black, White SpecifyBla	e, etc.
215-0036	Imin 72 nou e. ian "natural Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5-	(Give	dent's Usual Occup kind of work done OO NOT use retired	during most of worl	king	 6b. Kind of Business/	•
12 p	Hygiene. Other than "r ent, the Medi		9+h 17. Father's Name (First, Middle, Last)	Wel	der	18. Mother's Nan	Be (First, Middle, Ma	ethlehem aiden Surname)	Steel
⊆ .		To Be	unknown			unknow			
Τ,	alth ar 27 is r trau		19a. Informant's Name/Relationship (Type. Print) Pauline Peele (daughte	1				City or Town, State, Z	• ,
nore	rages la lent of Hez nt: If item ry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Quantion 5 ☐ Other (Specify)	20b. Place of Dispondermetery, crem Mt. Zio	natory or other plac	e)		c. Location - City or	
Baltimor	permit. rages Department of Important: If it any Injury or of		21. Sgnature of Funeral Service Licensee	MC 210	Name and Addre	ss of Facility SCruq	gs Funei	Balto, ral Home	Md
	호스트 등 이		23a. Part 1. Enter the disease, or complications that cause to	he death. Do not ente	412 E. er the mode of dyir	Preston ig, such as cardiac	St. Ba	lto.Md.	21213 Approximate
	hysician		shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition	sclerot	tic car	diovascu	lar dis	sease	Interval Between Onset and Death
	/Medical ixaminer		Due to (or as a	consequence of):					
7	nsit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	consequence oi).					
ວ ົ	hysician and the burial-transit		that initiated events c	consequence of):			···		
08/00	physic as the b	Nedical	d						
The law resulted that the death continued to	d by the attending pridetached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of the pregnant at the pregna	Petal death 3] Ectopic pregnancy] Other (specify)	/		23d. Date of deli Month	very Day Year
cords, F.C	been signed by should be detac	ğ	Part II. Other significant conditions contributing to death bu	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tobac	cco use contribute to	,
ביישהן סיון.	te has been signage 2 should	Completed					24a. Was an autopsy performed	24b. Were autoprior to death?	topsy findings available completion of cause of
VII di	sertifica rector,	Be	25. Was case referred to medical examiner? 1		Othe	\r:	(Check only one)		
	After this funeral di	ion: To	27. Magner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day)	28b. Time of	28c. Injury Work	at ?	me 5 ☐ Residenc 28d. Describe how	e 6 Other (Speci injury occurred	ify)
DIVISION OF VICE	within 24 hours after death. To the Funeral Director: After this certificate has technicisely filled in by the funeral director, page 2	ertification:	2 Cuicide 6 Could not be	r - At home, farm, stre (Specify)		Yes 2 □ No	28f. Location (Stree City or Town, S	et and Number or Ru tate)	ral Route Number,
d Hoenita	within 24 hours a To the Funeral D completely filled	Medical C	29a. Certifier (check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	xamination and/or inv	occurred at the time time estigation, in my of	ne, date and place, pinion, death occur	and due to the caus	se(s) and manner as e and place, and due	stated. to the cause(s)
P P	To th comp	Me	29b. Signature and title of certifier	nD	29c. License	number 53368	,	Date signed (Month)	
	2	-	30. Name and address of person who completed cause of de	ath (Item 23a) (Type, I					re, MD, 21287
	Star Registra	.0	31. Date filed (Month, Day, Year) 32. Registrar	Signature		0001	TOTAL WOILE	Ji, Dailiiilo	10, IVID, 2120/

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 2, Physician/ A^{M} 2010 9:30 ubel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard E1kridge 7345 Gardenview Drive If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral 1 X M 2 - F Hours 10-19-1997 Director 214-51-4099 13 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD E1kridge Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7345 Gardenviwe Drive 21075 United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeffrey Thomas Lubelczyk Julia A. Schroer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Julia A. Lubelczyk – mother 7345 Gardenviwe Drive, Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Crestlawn Mem. Gnd. 12-08-2010 | Marriottsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at of Fundral Service Licens MMP., Inc, 7250 Wash. Blvd., Elkridge, MD 21057 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shockly or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Opset and Death Priysician/ multisystem failure wit odain disease or condition Medical resulting in death) Due to (or as a sequence of) **Examiner** tochondria Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Dolu smerase the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (er as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown as been signed by the 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy , page certificate l Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ neral Director: After this filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 12/3/10 D006104

Registrar

DHMH 17 Rev 7/2009

State

225 greene St

32. Registre's Signa

737 W Lombard # 199 Balt MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) McDONALD Physician/ MARLENE M DECEMBER 7, 2010 6:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MIDDLE RIVER 3726 SENECA GARDENS ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1-24-1934 Days Hours Min. 1 M 2 1 76 MARYLAND 215-30-0151 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Director MIDDLE RIVER BALTIMORE 1 Tyes 2X No MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 23a Funeral 3726 SENECA GARDENS ROAD U.S.A. items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 XNo Black White, etc. . or \$ 1 Never Married 2 Married hours after Maryland 21215-0036 1 Yes 2 XNo Specify. Specify id Mental Hygiene. marked other than "natural", WHITE Completed 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 72 Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE SCHOOLS **EDUCATOR** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H MUTH) WEBSTER LILLIAN HERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1200 PRIMROSE AVE ROSEDALE, MD DARLENE RASINSKI/DAUGHTER f Health Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State HOLLY HILL MEM.GD: 12-10-10 BALTIMORE, 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funer Fervie Licenses ROSEDALE, MD 21237 1211 CHESACO AVE Approximate Interval Between Onset and Death ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONGESTIVE HEART FAILURE Physician/ 10 YEARS disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 10 YEARS AORTIC STENOSIS Sequentially list conditions, Due to for as a consequence of n any, leading to immediate cause. Enter Underlying Cause (Disease or linjury 10 YEARS death certificate be executed MITRAL STENOSIS burial-transi that initiated events Due to (or as a consequence of resulting in death) Last physician Physician/Medical 10 YEARS RENAL FAILURE, CHRONIC attending physic for use as the b 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 n Month Day Year Yes 2 XNo signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIAL FIBRILLATION 1 XYes 2 No 3 Probably 4 Unknown Records, cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available 24a. Was an CORONARY ARTERY DISEASE autopsy prior to completion of cause of death? DIABETES MELLITUS TYPE II Yes 2 X No 1 Yes 2 No certificate To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; to the funeral director; the funeral director; the funeral director; the funeral director; the function of the function of the funeral director; the function of the fun 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Be examiner?

1 Yes 2 XNo Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 X Natural 5 Pending M Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) Medical 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of cowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 9c. License numbe 29d. Date signed (Month, Day, Year, D0046458 DECEMBER 8, 2010

Registrar DHMH 17 Rev 7/2009

State

Jarke

9515 HARFORD ROAD

BALTIMORE, MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

PEET

MD

. Registrar's Signature

THERESA

Date filed (Month)

Day, Year, 9 20

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene per me,g910,12/17/2010dhb.
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Kanda December 2010 1925 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months 1 XM 2 □ F Days **Director** 421-60-6730 63 Alabama July15,1947 Usual Residence of Decedent the Maryland 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits South Carolinia Director 1 X Yes 2 □ No Columbia Richland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2026 Fairlamb Avenue Funeral 29223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 No Y Yes 2 [If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working
life. DO NOT use retired)
Religious
rograms Specialist (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Chaplain's Office 12 Programs U.S. Navy 17. Father's Name (First, Middle, Last) injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) Be Dewey Britten McDaniel Mary Elizabeth Crawford 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29223 permit. Pages 1 and 2 Department of Health a Important; if item 27 is any injury or other trau Angela_T. Martin 2026 Fairlamb Ave., Columbia, South Carolinia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town State 1 XBurial 2 Cremation 3 Removal from State Jackson nal Cemetery 12-10-10 Columbia, SouthCar. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michael 6009Harford Road, Baltimore, Maryland21214 Part 1. Enter the disease, or conshock, or heart failure. List only or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only ne cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Massive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence on) CERTIFICATION APPROVED BY INEDICAL The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as ding p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Dav 5 Other (specify) Yes 2 No P.O. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 2 No 3 □ Probably 4 □ Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy has page 2 performed? 2 No 1 Yes 2 🗌 No Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \sum Nursing Home 1 Impatient 3 DOA ၉ 2 ER/Outpatient 5 Residence 6 Other (Specify) Division of 27. Manner of Death 1 Vatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No death. 2 Accident filled in by the after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Hospital 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) onel and manner stated within 2 To the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

David

31. Date filed (Month, Day, Year)

(ian

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 Day Physician/ Decth. 2010 Year Carolyn D. McCall 12:25p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Director 194-18-1355 91 WVZ act 9 1919 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits with the Maryland Director Middle River Baltimore MD 1 🗌 Yes 2 😿 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 USA 119Coveredwagon Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Misty Harbor 10+hand Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important If item 27 is marked any injury or call. ၉ Kate Blankship Hugh Duley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coveredwagon Road Balto. MD 21220 Wanda Vinson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Holly Hill Cemetery 12/9/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. 21. Sign wire of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the getth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician GASTROINTESTINAL BLEED disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) the Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🗶 No 1 🗌 Yes မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🛣 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Investigation Accident filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

7 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 010

Registrar

State

JACKIE

31. Date filed (Month, Day, Year)

JONES,

09

DECEMBER

CAROLYN

2300 DULANEY VALLEY RD

32. Registrar's Signature

TIMONTUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Louise Mary Murphy Dec. 7:28,0 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Baltimore Towson 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X**X Months Davs Hours Min. $Aug.4^{(Month, Day, Year)}33$ 218-30-702 77 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Middle River Baltimore MD 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 Clearlake Lane 16 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Maryland Executive Administrator 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MAria Philippi Alfred Matani 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16 Clearlake Lane Baltimore MD 21221 19a. Informant's Name/Relationship (Type, Print) Richard D. Murphy /husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
PArkwood Cemetery 12/4/10 1 XBurial 2 Cremation 3 Removal from State Baltimore MD 4 Donation 5 Other (Specify) . Signature of uneral service me and Address of Facility 300 MAce Ave. Balto. Connelly Funeral Home of Essex MD Balto. 21221 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or shock, or heart failure. List of Pancreatic Carcinoma Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant Unknown Month Pregnant at time of death 5 Other (specify) Dav Year signed by the at d be detached for 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an certificate has birector, page 2 s perform the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 No Other: Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury ☐ Accident ☐ Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 3 [only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

ORIGINAL

32. Registrar's Signature

Mace

29c. License number

D61907

Avenue, Bautimore

29d. Date signed (Month, Day, Year)

10

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2010 Mehrling December 10:10 pM Mary Hocking /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Glen Meadows Glen Arm 8. Date of Birth (Month, Day, Aug 15, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1922 Months Days Min. Hours Mary land 1 □ M 2 🕡 F 218-14-1494 88 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore **Baltimore** 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7710 01d Harford Road 21234 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify ò Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Retail/ Elementary/Secondary (0-12) College (1-4or 5+) Store Detective Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alfred Ε. Hocking Laura Keyes ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen J. Stine-daughter 7710 Old Harford Rd., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Stone Chapel Cemetery 12/9/10 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, d attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director; filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) LLING (ROSEROADS KAMANY 31. Date filed (Month, Day, Registrar's State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 Physician/ DECEMBER 950 AM Miller 2010 Lee Daniel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL OF BALTIMORE BOLTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X**□ M 2 □ 248-70-3944 Director 65 02 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 X Yes 2 □ No MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 21217 505 Schroeder Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Black 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 12th grade College (1-4 or 5+) National Shirt Shop Salesman na Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ esse Miller Ruth Colvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 Ruth Gethers-Mother North Arlington Ave #602, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/8/2010 Arbutus Memorial Arbutus, Md tur 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21. Sign Funeral Service Licensee Ave, 21215 23a. Par 1. Enter the diseashook, or heart falure. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, p. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final BILATERAL PNEUMONIA Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner REWAL if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? page 2 should be detached for Month Year Day Pregnant at time of death Yes 2 No the g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 ☐ Yes 2 ✓ No Yes 2 No the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No 1 Natural 5 Pending iniurv Investigation Accident Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by 4 Homicide determined City or Town, State Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D63170 DECEMBER, 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BALTIMURE, MD YED A RIZYI STNAT MD 32. Registrary Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BURN Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE RANDALLSTOWN SEASONS HOSPICE 1 Year If Under 2 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Social Security Number 1 **X**M 2 □ F Days Country) Months Hours 01116-11927 SC 83 Director 251-36-6383 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 X Yes 2 No BALTIMORE TURNER STATION 10e. Street and Number 10g. Citizen of What Country? Funeral 21222 USA 121 MAIN STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify: BLACK Specify: 3 Widowed 4 Divorced Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natuiury or other traumatic event, the Medical jury or other traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) STEEL WORKER BETH STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ JOSEPHINE SMITH JACK MARTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BESSIE MARTIN/WIFE 121 MAIN STREET, BALTO., MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HOLLY HILLS 12/11/10 ESSEX, MD 21 Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ 10 disease or condition Medical resulting in death) Due to (or s a consequence of) **Examiner** Sequentially list conditions, Examine Due to or as a consequence of cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Day Yea Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 N After this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 18-19 Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title

Registrar

DHMH 17 Rev 7/2009

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G910,1279/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day, Physician/ MacKenzie Betty December 2010 10: A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 819 Staffordshire Road Cockeysville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth
(Month, Day, Year,
Aug. 21, 9. Birthplace (State or Foreign **Funeral** Months Days Min 1 □ M 2 🗓 F Yrs. Virginia Director 228-32-0565 80 1930 Aug. Usual Residence of Decedent show 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2010 Funeral 819 Staffordshire 21030 Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene.
Important: if item 27 is marked any injury or Att. 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give MacKenzie Dec. 7; **Maryland 21215-0036** 1 ☐ Yes 2 🕅 No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marion Ruth Derring Moore Philip Lee a Informant's Name/Relationship (Type, *Print*) **Donald** Doanld MacKenzie/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Staffordshire Road Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 8 cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 2010 Timonium, MD 21. Signature of Funeral Service Licens Lemmon Funeral Home of Dulaney Valley. 10 W. Padonia ROad Timonium, MD 21093 Michae1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) multiple murclong Medical Due to (or as a conse vience of): **Examiner** Sequentially list conditions. Examine cause (Disease or linjury Due to (or as a sonsequence oi). attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 month 1 Yes 2 No Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 1 🗌 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, æ 25. Was case referred to dical 26. Place of Death (Check only one) examiner? Other: No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) Bruce Rosenberg 21 West Road Suite 100Towson, Maryland 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

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ederick Clinto	n M	ıgula S 1-For State	tate of Maryland	/ Depa	artment of F rtificate of D	lealth an			201	0 38658
Physici ledical Exami		1. Decedent's Name (First, Mid	1. 4/1 .					2. Date of Dear Month December		3. Time of Death 1907 hrs
)	iii Ci	4a. Facility Name (if not institut	ion, give street and number)	•	4b.	City, Town, or Catonsville	Location of De		4c. County of Anne Aru	Death
Funeral		14 Rambling Oaks V 5. Social Security Number		je (In yrs.		If Under 1 Yea	r If Under 24	Hrs. 8. Date of Bir		9. Birthplace (State or
Director		422-51-3401	1 M 2 F	39	Yrs.	Months Day	s Hours M	10/25	11971	Countyganda
any		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	, Town or Location					10d. Inside City Limits
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death with the Maryland or items 23a or 28a-f shaust be notified at one	Director	10e. Street and Number 14 Rambling	Oaks Way	Ap	1. L	Of. Zip Code	228		Dg. Citizen of Wha	
ath with	Funeral	11. Marital Status 1 Never Married 2	12. Was Decedent Armed Forces?	?			spanic Origin? (n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - White,	American Indian, Black, etc.
after de al", or i	by Fu	3 Widowed 4 D	ivorced If Yes, Give Year or Dates:	∑ No		es 2 No			Specify:	African
2 hours "natur		15. Decedent's Education (Sp Elementary/Secondary (0-12			16a. Decedent's during most		tion (Give kind of DO NOT use r		16b. Kind of Busin	age Services
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21215-0036 ald be filed within 72 Mental Hyg ene. marked other than event, the Medical	Be	Treather's Name (First, Middle Stopher	1 1 - 1				- C - 1	me (First, Middle, N	1	e
M 3 4 = 1	2	19a Informant's Nation Relation	iship (Type, Print) (W;	fc)		/ 1	1	Baltimo		State, Zip Code)
		20a. Method of Disposition	on 3 Removal from Sta		Place of Dispositio crematory or other	n (Name of cer	metery,	Date	20c. Location - C	ity or Town, State
Baltimore, bermit. Pages 1 a Department of He important: If ite		4 Donation 5 Other 5 21, Signature of Funeral Service	Specify:	Ki	berutan	rily (er	netery 1	2/17/10	Kitend	le, Uganda
Ba perm Depa Impo injur		Vaugh C.	Treese		515	1 Bal	to. Na	eene fu t'I Pilce	CHLL	7)
Physician \/Medical		23a. Part I. Én er the disease, of failure. List only one cause	e on each line.			node of dying,	such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Myocardi Due to (or as a conse							
sit d	Examine	(Disease or injury that initiated events resulting in death) Last	C.	equence o	rf):					
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Division of Vital Records, and or Attending Physician: The law requires after decora. The rectors and prectors after this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Certification:	3 Suicide 6 Cou		jury - At h	ome, farm, street, f	actory, office b	uilding, etc.	28f. Location (S or Town, St		or Rural Route Number, City
Hospi 24 hou Funer	Medical Ce	29a Certifier 1 Certifying F	Physician: To the best of my aminer: On the basis of exar		-					
To the within To the comple	Med	29b. Signature and title of certification	and manner stated, ier			29c. Licens	e number		29d. Date signed	(Month, Day, Year)
(5 %)		30. Name and address of perso	Durbo completed course -6 d	eath /lis	230)	O.C.I	И.Е. 		December 5,	2010
SE Pais		Donna M. Vincenti, N	1D Assistant Medic	al Exar	niner 111 P	enn Street,	Baltimore,	MD 21201		
St Regist	tate trar	31. Date filed (Month, Day Year DEC 0 9 2010	32, Registra	s Signat	arks					

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State of Maryland / Department of Health and Mental Hygiene

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Physiciar Medical Examin	1/	Decedent's Nam Pamela Mye		Last)							Date of Deat Month November	th	Year		of Death
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	runeral	11. Marital Status 1 Never Marri	ed 2 Marr	ied 12. Was Deceder Armed Forces 1 Yes		5. 13.			spanic Origir n, Mexican, F		fy Yes or No- an, etc.)		14. Race - Am White, etc.	erican Indi	an, Black,
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876 tificate ng phy as the b	2	IF FEMALE: 3b. Was decedent past 12 months	pregnant in the	23c. If yes, outco	me of pregna	ancy 2	Fetal death	n 3	Ectopic p	pregnancy		1	. Date of delive Month	ery Day	Year
Sox 6 leath cer e attendi for use			or No 9 ✔ Unkno	1 7 1	t time of deat		Other (Spe	ecify)				1			
that the danced by the detached		Part II. Other signi	ficant condition		th but not res	sulting in th	ne underlyin	g cause	given in Part	I,	23e. Did to	bacco u	use contribute	o the caus	e of death?
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Records, The law requires ficate has been sig				n a						[24a. Was a autops perforr	sy		completic	dings available in of cause of
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Division ospital or Attending spital or Attending tours after death. neral Director: After filled in by the fune for the filled or the fune for the filled or the fune for the fune fune for the fune fune fune fune fune fune fune fun		3 Suicide 4 ✔ Homicide	6 Could r determi	ot be				y, onice i	ounding, etc.				oulevard, Lau		s Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Divisional Expedition 15.	2 - -	29a. Certifier 1		sician: To the best of n	ny knowledge	e, death oc	curred at th			e, and due	to the cause	e(s) and	d manner as st	ated.	e)
To the Hos within 24 h To the Fur completely		one) 2 🗹		and manner stated	amination and	Jor Invest			se number	ired at the	e time, date a		ate signed (N		
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3		30. Name and addre		no completed cause of sistant Medical E			enn Stree	et Ralt	imore, Mi	7 21204		-			
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		-	State of Maryland / Department of Certificate of Ce		rgierie 0 38660
	Physicia /Medic Examin	an al er	1. Decedent's Name (First, Middle, Last) DONALD JOSEPH MALON	2. Date of Digoth, or Location of Death	Day Year 3. Time of Death Lo 2010 9-15 P M 4c. County of Death BA/TO
	Funeral Director		215-12-3728	vs Hours Min. (Month, D	Ay, Year) Country 1921 Maryland 10d. Inside City Limits 1 Yes 2 No
Saltillore, Malylally 21213-0030	permit. Pages 1 and 2 should be filed within 72 hours eiter death with the Maryland Department of Heath and Mental Hygiene. Important: If time 27 Is marked other than "natural, or Items 23a or 28a-f show any injury or other treumatic event, the Madical Eventh or must be rediffed a page.	To Be Completed by Funeral Director	10e. Street and Number 601 Maiden Choice Lane #218 10f. Zip Code	21228 of Hispanic Origin? (Specify Yes or Nouban, Mexican, Puerto Rican, etc.) No Specify: cupation one during most of working titred) 18. Mother's Name (First, Middle Rosemary E. Seriest and Number or Rural Route Number of Gardens #407 felace) Date of place) Original Control of Specify: Date places of Facility Board 655 Ward Control of Specific Ward Control of Ward Control of Ward Control of Specific Ward Control of Ward Control of Control	10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry naval intelligence a. Maiden Sumame) Sullivan
	Physician /Medical Examiner	cai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shack, or heart failure. List only one cause on each line.	dying, such as cardiac or respiratory	Onset and Death
O. BOX 68	0 0	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnant at time of death 5 □ Other (specific pregnant at time of death 9 □ Unknown		23d. Date of delivery Month Day Year
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SION OF VITAL	Physicien: this certifica ral director, p	To Be C	2 Accident investigation M	26. Place of Death (Check only Other: 4 Nursing Home 5 Re Injury at Work? 1 Yes 2 No	or one) sidence 6 □Other (Specify) show injury occurred
DIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Diractor: After completely filled in by the fune.	edical Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify) 29a. Certifier (Check only 2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in	City or 7	(Street and Number or Rural Route Number, own, State) le cause(s) and manner as stated. e, date and place, and due to the cause(s)
	To the H within 24 To the F complete	Medi	one) and manner stated.	cense number	29d. Date signed (Month, Day, Year) NOV L9, LDID 4LTIMORE, MD 21229
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMBAND AM BASKSKW 3455 Will	KENS AVE B.	4LTIMORE, MD 21229

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2010 ar 11:05 PM Jacqueline Marie Maloney December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hospice Casey House Rockville Montgomery Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Min. 217-44-6129 65 **Director** March 1945 Washington, D.C. Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 X No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4901 Adrian Street 20853 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🔼 No Black, White, etc. 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bookkeeping Concrete Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Bernard Maloney Montley Jean Robinson 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 i 9508 Glade Avenue, Walkersville, Maryland 21793 Thomas Bernard Maloney, II/ 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o December cemetery, crematory or other place) X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 8, 2010 Rockville, Maryland Signature of Fun Service Licensee 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Anal Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Uisease or imjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Other (specify) Day Year Pregnant at time of death s been signed by the same should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown icate has been s ; page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \nwarrow Other (Specify) Hospice 1 ☐ Yes 2 🔀 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 23 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Nicole Christenson,

DEC 0 9 2010

CUNT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

29c. License number

R120698

6001 Muncaster Mill Road, Rockville, Maryland 20855

29d. Date signed (Month, Day, Year)

December 5, 2010

Physician/ Medical <u>Exa</u>miner Examine or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division of Vital Records, P.O. Box 68760

permit, Page 1
Department of I
Important: If it
any injury or or

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

Director

Funeral

Completed by

Be

မ

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If ifew 27 is marked outher than "natural", or items 23a or 28a-f sho ant: If item 27 is marked outher than "natural", or items be notified at ury or other traumatic event, the Madical Examiner must be notified at

Baltimore, Maryland 21215-0036

been signed by the attending physician and should be detached for use as the burial-tran , page 2 completed filled in by the funeral director,

After this certificate has

hin 24 hours after deat the Funeral Director:

Hospital

Completed by

Be

Certificate: To

Medical

only one)

29b. Signature and title of certifier

that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Tyes 27. Manner of Death 1 X Natural work? 1 Pes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D41866

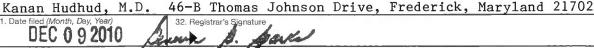
29d. Date signed (Month, Day, Year)

December 8, 2010

State Registrar

31. Date filed (Month, Day, Year) **DEC 0 9 2010**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of Maryla		artment of tificate of			giene Reg. Nø? () ()	38663
	Physicia	en/	1. Decedent's Name (First, Middle, Last)	-11			-	2. Date of Dea	ath	3. Time of Death 9:00 A _M
	Medic Examir	cal	Kenneth Ma: 4a. Facility Name (if not institution, give str.	eet and number)	-	4b. City, Town, o	or Location of De	December eath	2010 4c. County of Dea	
and I) LAGITIII		Brighton Gardens			Colu	mbia		Howard	
	Funeral Director		100 11 1200 11	M 2 □ F 7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Year Months Days		lrs. 8. Date of Birt lin. (Month Day May 19, I	th 9. B X Xear) C	irthplace (State or Foreign ountry) New York
	show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo					10d. Inside City Limits
	r 28a-f notifie	Direc	MD Howard 10e. Street and Number			Columbia	1		10g. Citizen of What C	1 🗆 Yes XX No
	s 23a c ust be	Funeral Director	7110 Minstrel Way			101. 2.15 0000	21045		United St	
920	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married 3 Nowel 4 Divorced	Was Decedent Ever in U Armed Forces? 1	1	Was Decedent of Information of Info	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi Specify: B	
21215-0036	thin 72 hour ene. than "natu he Medical	Completed by	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give I	dent's Usual Occu kind of work done O NOT use retired CPA	during most of v	vorking	16b. Kind of Business	•
Maryland 2	d be filed wi Mental Hygid Irked other Itic event, ti	To Be (17. Father's Name (First, Middle, Last) Clifford Maxwell			OI A	I	Name (First, Middle, e Dodds	•	SCIIDULOI
, Man	nd 2 shoul salth and I n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Leslie King-Hammon)	Print) d (Niece)	19b. Mailin 2021	ng Address (Street Madison	^{and Number or} Avenue	Rural Route Number Baltimo	r, City or Town, State, Z re, MD 212	Rip Code) 17
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition 1 ☐ Burial 2 【X】 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, cren	sition (Name of natory or other pla c Cremat		Date /6/2010	20c. Location - City of Glen Burn	
Balti	permit. Pepartm Departm Importa any inju		21. Signature of Funeral Service Licensee	Groll					1 Homes, Inc. MD 21045	
	Physician/		23a. Part 1. Enter the disease, or complic shock, or eart failure. List only one of Immediate Cause (Final disease or condition	ations that Jus the dea cause on Sch line. Coronary			ng, such as card	iac or respiratory arr	est,	Approximate Interval Between 2015 Feat Seath
	Medical Examiner	L	resulting in death) Sequentially list conditions, b.	Due to (or as a consective Congestive)		failure				10 Years
k	uted Id ansit	Examiner	deuge interest in the cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	Due to (or as a conse	vience of):					
k 09	ate be executed physician and the burial-transit	edical E)	resulting in death) Last	Due to (or as a consec	quence of):					
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 🗌	Ectopic pregnan Other (specify)	су		23d. Date of di Month	elivery Day Year
s, P.O.	ires that the signed by id be detacted		Part II. Other significant conditions control	ibuting to death but not re	sulting in the u	nderlying cause g	ven in Part I.		obacco use contribute t Yes 2 □ No 3 □ I	o the cause of death?
Division of Vital Records,	The law requate has beer page 2 shou	Completed by						24a. Was a autop perfor 1 □ Yes	osy prior to rmed? death?	utopsy findings available completion of cause of
Ita	certific rector,	Be	25. Was case referred to medical examiner?	spital:		Oth	lace of Death (C	heck only one)		Assisted Living
of V	ng Phys ter this neral dii	te: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time of injury	t 3 L DOA 28c. Injur	4		lence 6 \(\) Other (Spe) ow injury occurred	cify)
ivision	or Attendir after death. Director: Af in by the fu	Certificate:	1. ↑ ↑ Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, stre	M 1 🗆	Yes 2 No	28f. Location (S City or Town	treet and Number or Ri n, State)	ural Route Number,
Ω	ne Hospital n 24 hours ne Funeral	Medical	(Check 2 L Medical Examiner	an: To the best of my know : On the basis of examination Practioner: To the best of m	on and/or invest	igation, in my opini	on, death occurre	ed at the time, date ar	nd place, and due to the	cause(s) and manner stated.
	To the within To the comp	_	29b. Signature and title of certifier	mi		29c. Licens D56		·	29d. Date signed (Moni	
	40		30. Name and address of person who com Harry Li 8600 Snowde	pleted cause of death (Iter n River Parkway	n 23a) (Type, P	rint) Columbia,	Maruland	210/5		
	Stat		31. Dep EC/10/9 02010 Den	n 32, Registar's Sign			· · · · · · · · · · · · · · · · · · ·	210-13		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	ate or iviaryi		artment of F rtificate of L			eg. No.2 0 1 0	38664
	Physicia	n/	Decedent's Name (First, Middle, Last) Fred Musser					2. Date of Death Month	Day Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give street a	and number)		4b. City, Town, or	Location of Death		ber 4, 201 4c. County of Dea	
			Baltimore Washingtor 5. Social Security Number 6. Sex			Glen If Under 1 Year	Burnie If Under 24 Hrs.	To be a special	Anne Ar	
ı	Funeral Director		5. Social Security Number 219–18–3982 Usual Residence of Decedent		rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth 01-16-1	923 9. Bir	rthplace (State or Foreign puntry) PA
	land f show d at	tor	10a. State 10b. County	10c.	. City, Town or Lo					10d. Inside City Limits
	e Mary r 28a-	Director	MD Anne Arunde	1		G1	en Burni		0g. Citizen of What Co	1 Yes 2 No
	with th s 23a o ust be	Funeral	100 Kent Road			Tot. Zip Code	21060		United	
و	filed within 72 hours after death with the Maryland Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	b	1 ☐ Never Married 2 ☐ Married 13	as Decedent Ever in med Forces? XYes 2 \(\square\) No		Was Decedent of Hi		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
200	ours af atural" cal Exa	eted		Yes, Give ar or Dates.		1 ☐ Yes 2 🔀 No				White
21215-0036	nin 72 h ne. han "n e e Medi	Completed	(Specify only highest grade con		(Give	kind of work done o O NOT use retired)	during most of work	ring	16b. Kind of Business	
d 21	led with Hygier other t ent, th	Be C	17. Father's Name (First, Middle, Last)			Manageme		ne (First, Middle, M		one Company
G	ould be filed wi d Mental Hygie marked other matic event, ti	욘	Fred Musser				(Unavai	lable)	Folk	
Mar	2 sho th an 27 is trau		19a. Informant's Name/Relationship (<i>Type, Pri</i>			-			City or Town, State, Zi	
Baltimore,			20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Remov	20	b. Place of Dispo				20c. Location - City or	
Ħ	Par		4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funer Service Licens e	Me		ge Mem Pa			Elkridge, fman Funer	Maryland al Home at
Ra	permit. Departr Importa any inji	E 3	Mark 13. 13	shaw						e, MD 21075
F	rnysician/ Medical Examiner		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	ns that caused the design of the constant of t	OB.	er the mode of dying $STAUPT$ (Approximate Interval Between Onset and Death
) [']	icate be executed physician and s the burial-transit	ledical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	Due to (or as a cons						
Rox PR	death certif ne attending ed for use a	Physician/Med	in the past 12 months?	yes, outcome of pre Live Birth 2 Pregnant at time Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	livery Day Year
s, P.O	ires that t signed b d be deta	ρ	Part II. Other significant conditions contribut	ing to death but not	t resulting in the u	ınderlying cause giv	en in Part I.		eacco use contribute to	o the cause of death?
Vital Records,	re lav Itchas Iage 2	Completed						24a. Was an autops perform	y prior to death?	atopsy findings available completion of cause of
tal	cian: T certifica ector, p	Be	25. Was case referred to medical examiner?	al·		26. Pla	ace of Death (Chec			
ot o	nding Physician: 1 th. : After this certifica : funeral director, p	e: To	27. Manner of Death 28	1 Inpatient 2 a. Date of injury	28b. Time of	nt 3 □ DOA 28c. Injury	4 ∐ Nursing H	ome 5 Resider 28d. Describe how	nce 6 Other (Spec w injury occurred	cify)
noi	tending death. tor: Afte the fun	Certificate:	'1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year			? Yes 2 □ No			
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	al Cert	4 Homicide determined	e. Place of Injury - A building, etc. (Spe		eet, factory, office		28f. Location (Str City or Town,	reet and Number or Ru , State)	ral Route Number,
	Hospi 24 hou Funer leted fill	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: On only one) 3 Certifying Nurse Prac	the basis of examina	ation and/or inves	tigation, in my opinic	n, death occurred a	t the time, date and	d place, and due to the	cause(s) and manner stated.
	To the comp	2	29b. Signature and title of certifier	7	or 1	29c. License	number		9d. Date signed (Monti	
	2		30. Name and address of person who gomple	Pd cause of death //	Item 23a) (Type 1	Print)	0099		12/06	110
	J		Ellcoff Gonba	y mp	/411 A	redison	Parte 1)	rive, Gle	en Burnie,	and, 2061
	Stat Registra		31. DEC 0'99' 2010" Ceneur	32. Regultrar's S	auto				,	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 8, 2010 Charles F. Nelker, Jr. 5:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Pear Tree House Pasadena Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗷 M 2 🗆 F Days 6/6/1924^{ear} MaryTand 216-18-3544 86 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 8113 Loch Raven Blvd 21286 U.S.A. "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify. Specify: Completed 3 ▼ Widowed 4 □ Divorced Year or Dates Department of Health and Nental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumant event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore CPA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elizabeth Dorsch Charles F. Nelker, Sr. 1 and 2 should of Health and Ne item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8575 Main Ave Pasadena, Maryland 21122 <u>.awrence P. Nelker / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. 12/11/2010 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year 1 Yes 2 la 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been sig page 2 should b 1 ☐ Yes 2 ☐ № 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? performed' 1 🗌 Yes 2 🗀 N Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tyes 2 40 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending 1 Yes 2 Accident 3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 251 30. Name and address of person who completed cause of deat 100

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Dec 4, 2010 Year Physician/ Aloise W. O'Neill 9:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard Harmony Hall Assisted Living If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth 6 Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Nov 14, 1915 Days 1 🗆 M 2 🗶 F 488-32-7244 95 Missour Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he marified at or items 23a or 28a-f shov 10h County 10d Inside City Limits 10a. State 10c. City, Town or Location Director Howard Columbia MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 6336 Cedar Lane Apt. 264 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Elemntary School Teacher** Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Charles Irving Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann O'Neill Daughter 11525 February Circle #103 Silver Spring, MD 20904 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Dec 07, 2010 Atlantic Crematory, LLC Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service Lice Art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Between 0 Onset and Death 95 Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 performed? death? 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 45505Hd L14 Hospital 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) filled in by the funeral Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 2010 e (purber

State Registrar

31. Date fild (EC

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das

30. Name and address of person who completed cause of death (Item 23a) (Type,

3

32. Registrar's Signature

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Det. Physician/ 6^{Pay} 201 °€ 5:23р м Peterson Anna L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Essex 327 Savannah Road Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day, Year July26, Days Hours 1 □ M 2 😾 F 212-46-0400 Director 64 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or items on other trainment. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 XNo Essex 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA Savannah Road 21221 327 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc ò 1 Never Married 2 Married 1 Yes 2 No If Yes, Give White 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Executive Secretary Lockheed Martin 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Filomena Stavola Ansell Parsons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald Peterson Misty View Road Balto. MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Baynelet Wre Later 1984) 20c. Location - City or Town, State 12-13-2010 + Removal from State Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of F eral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of 23a. Part 1. Enter the disease or co shock, or heart failure. List only rollications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line Interval Between O set and Death Immediate Cause (Final Physician/ year disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on: after death. Director: After this certificate has been signed by the attending physician and In have the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the 1 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10 30. Name and address of person who 31. Date filed (Month, Day, Year) State

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Registrar

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:23a Physician/ 3 Day 201 Par Der. Charles William Plansky Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death ${\tt Towson}$ 4c. County of Death Gilchrist Center Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y Jan. 24 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months 220-76-9874 49 Country) **Director** Yrs 1961 MD Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Essex MD or 28a-f 1 Yes 2 XNo 10f. Zip Code 21221 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 532 Fuselage Avenue USA or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other transmitted." than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Snow Valley Water Route Salesman 1yr. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Stockett Charles Plansky Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 532 Fuselage Avenue Baltimore MD 21221 Robin Plansky /wife 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SacredHeartofJesus 12/7/10 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Bervice License 22. Name and Address of Facility 300 Ave. Mace Balto. MD 21221 Connelly Funeral Home of Essex 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a co quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte d be detached for Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnods Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s After this certificate has autopsy performed? Yes 2 No death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: မ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No s after death | Director: / completed filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 ly one dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. S nature an 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (M

oth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician/ Month Millian mer OR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5409 FANtail (Anou Skhesville DUIDE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☎ M 2 □ F Months Days Hours Min 167367 1945 Director 215-42-6530 65 MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5409 Fantail Dr. 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 K Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. 1968-88 Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Carroll Co. Schools Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic eveni 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Merrill Palmer, Sr. Doris Kammer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Palmer/Wife 5409 Fantail Dr., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) arlington National Cem. 3/4/2011 Arlington, VA 21. Signature of Funeral Service Licenses 2Burrferd Gaden Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Fart 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence f) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence on Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 410 2 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

ours after death.

eral Director: After this certific filled in by the funeral director,

within 24 hours a To the Funeral L

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Medical

29b. Signature and title of certifier

5 Pending

Investigation 6 Could not be

determined

Matural

2 Accident
3 Suicide
4 Homicide

29a. Certifier

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

and address of person who completed cause of death (Item 23a) (Type, Print)

Couter Street Westmuster, MD 21157 32. Registrar Signat

1 V Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State o	of Maryla		epartme C <i>ertifica</i>			and M	1ental Hy	giene Reg. No	2010	3	8670
			Decedent's Name	(First, Middle, L	ast)							2. Date of De	ath		3. Ti	me of Death
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2			Stella Ma 5. Social Security Nur		Sex	7. Age (In yr	e last hirthd		moniu	M If Under	r 24 Hrs.	8. Date of Bir	th.	Baltim		tate or Foreign
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	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (Fit	rst, Middle, Las	1)					18. Moth	ner's Name	(First, Middle,	Maiden	Surname)		
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BEE			1 ☐ Burial 2 ☐ 4 🔀 Donation 5			State A		crematory of Gifts I			12/0	9/2010	Ha	nover,	Marv]	and
DECEMBER 4, 2010 Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		21. Signature of Fune	eral Service Lice	hsee		7		and Addres					ts Regi		
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				failure. List only	mplications that of one cause on ea	caused the de ach line.	eath. Do not	enter the me	ode of dyin	g, such as	cardiac o	r respiratory ar	rest,		Interva	ximate al Between
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Box 687	ertifica ding p se as t	/Me	IF FEMALE:		23c. If yes, out	tcome of pred	nancy							004 D-46-4-	e. 25.	
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[A]	sician; The la certificate ha lirector, page 2	Be c	25. Was case referred examiner? 1 ☐ Yes 2 🔀		Hospital:		m		Oth	ace of Dea						
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	Fo the within Fo the complex c	Σ	only one) 3 2 29b. Signature and		irse Practioner:	TO THE DEST OF	Thy Knowled		9c. License		e and plac	e, and due to tr		ate signed (Mont		ır)
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0			JACKIE J			OO DIII.		VALLEY	RD.	TIM	ONTIN	1, MD 2	1093	<u> </u>		
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			For State Registrar	State of Ma	aryıan		irtment d tificate d			d Menta		20	10	38671
	· ·	,	Decedent's Name (First, Middle, L.)	ast)		007	incare c	n Dea		2. Date	of Dooth	No.	1 0	3. Time of Death
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	Examir	ner	4a. Facility Name (if not institution, gi Gilchrist	e street and number)			4b. City, Tow		ation of De	eath		4c. County	of Death timo :	20
	Funeral			Sex 7. Age	(In yrs. la	ast birthday)	If Under 1 Y		Jnder 24 H		of Birth		9. Birth	place (State or Foreign
	Director		212-48-9913	1 X]M 2□F	63	Yrs.	Months Da	ays Ho	ours M	July	Th, Day Ye	^{ar)} 1947	Ma	ryland
	land show dat	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	ation						1	0d. Inside City Limits
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	s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral Director	10e. Street and Number				10f. Zip Cod		-		10g	. Citizen of W		ntry?
	ems 2 r mus	nue	316 Chapelwood 11. Marital Status	Lane 12. Was Decedent E	ver in U.S	3 13 W	as Decedent		ic Orlain?	(Spacify Vae	or No-	U.S		
9	ter de , or ite		1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2121		If	Yes, specify C	Cuban, Me	exican, Pu	erto Rican, et	c.)		- Americ , White,	an Indian, etc.
8	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates.			☐ Yes 2 🗓					Specify:	Whi	te
-51	172 hc in "na Medic	mple	15. Decedent's (Specify only highest of	rade completed)	_ n	(Give ki	ent's Usual Oc nd of work do NOT use retii	ne during	most of v	orking	16	b. Kind of Bu	siness Ind	dustry
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and	e filed ttal Hy ed oth eveni	To Be	17. Father's Name (First, Middle, Last		_			18.	Mother's N			den Surname)		
Maryland 21215-0036	should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec		Frank 19a. Informant's Name/Relationship	Paul	R	agonese			, ,_	Margai		F.		Ischer
	ge 1 and 2 should be filed within 72 hour it of Health and Mental Hyglene. : If item 27 is marked other than "natu or other traumatic event, the Medical		Paul Ragonese	Brother		1	Address (Stra apelwo					y or lown, St Marylai		
Baltimore,	e 1 an of He If item or othe		20a. Method of Disposition		20b. P	ace of Dispos	tion (Name of	f		Date		c. Location -		
ţį	t. Pag tment rtant: njury o	a	1 X Burial 2 Cremation 3 4 Donation 5 Other (Spec		Du	Taney Crem Laney S error 1a				-10-201				Maryland
Bal	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funecal Service Lice	see •••		22.	Name and Ad	Idress of F	Facility I			Funera aryland		ome, Inc.
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	plications that caused	the death	n. Do not enter	the mode of o	dying, suc	ch as cardi	ac or respirat	ory arrest,	ar A raile		Approximate
	hysician/	1	Immediate Cause (Final disease or condition	During	nan	a ex	monte	inn					1.	Interval Between Onset and Death
77	Medical Examiner		resulting in death)	Due to (or as a	consequ	en / of):	/	- 6-2						
	-	ner	Sequentially list conditions, if any, leading to immediate	b. Que to (or as a	consequ	ence of):	Chi	100	7				V	nonths
PK	tuted and ransit	tami	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	C										
, V	Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	resulting in death) Last	Due to (or as a	consequ	ence of):								
092	cate b physis	edic		d			_							
.89	eath certifice attending p	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			Esta la mon					23d. Date	of delive	rv
Box	death he atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at	time of de	eath 5	Ectopic pregn Other (specify					Mon		Day Year
P.O.	v requires that the de been signed by the should be detached		Part II. Other significant conditions	ontributing to death bu	t not resu	ulting in the und	derlying cause	e given in	Part I.	23e	Did tobacc	Co use contrib	ute to the	e cause of death?
Is, F	uires the signeral of the sign	Completed by	Coronary all	ery dete							1 Yes		2.4	ably 4 Unknown
Ö	law req has bee e 2 shou	plet	1	7						24a.	Was an	24b. W	ere autop	sy findings available
Rec	hysician: The lar his certificate ha I director, page 2	Com								1 0	autopsy performed Yes 2	2 de	ath?	npletion of cause of
ital	sician; The certificate I irector, page	a B	25. Was case referred to medical examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:				Othor		eck only one,				
of V	g Physer this eral di	و: 2	27. Manner of De th	28a. Date of injury	. :	ER/Outpatient 28b. Time of	3 □ DOA 28c. In	4 L njury at	Nursing			6 X Other		Mospiy
ono	Attending P r death. ctor: After t y the funera	licat	1 Natural 5 Pending 2 Accident Investigation		Year)	injury	w	ork?	2 🗌 No			jury occurred		
Division of Vital Records,	or Att	Certificate:	3 Suicide 6 Could not 4 Homicide determined	28e. Place of Injury building, etc.	y - At hon (Spec <i>ify)</i>	ne, farm, stree	t, factory, offic	се			ion (Street or Town, Sta		or Rural I	Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu		29a. Certifier 1 Certifying Phy	sician: To the best of m	ıv knowle	edge, death oc	cured at the ti	me, date	and place	and due to t	ne cause(s)	and manner	as states	
	he Ho iin 24 t he Ful ipletec	Medical	(Check & Medical Exam	iner: On the basis of exa se Practioner: To the be	mination	and/or investig	ation, in my on	pinion dea	th occurre	at the time	tota and ale	aca and duat	o the caus	se(e) and manner stated
	To the within 2 To the comple		29b. Signature and title of certifler	1			0	ense numb	1 -		-	Date signed (1
		-	20 Name and address of a sure	MID	4h /4.	00+) /T = 2 :		500	205		1 UC	ecm	su	1 7010
	12		30. Name and address of person who	nn PP		4	NIC	era	se.	ST	Town	er	MD	
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Registrar	s Signatu	ire						4-4		
		_	nec 0 9 2010	32. Registrar	s Signatu	re V.								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** DECEMBER GORDON C. RUMENAP 200 1242 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST AGNES HOSPITAL BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ₹ M 2 □ F Months Days Hours 214 22 9394 83 Director 28 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Evariation at the Invited at 1 ☐ Yes 2 ☐ No Directo MDAnne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8541 Bay Rd. Funeral 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 194 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1945-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced 1946 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor <u>Westinghouse</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Joseph Rumenap Bertie West 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trau once. Carole Rutley = daughter 815 Scott Circle Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Glen Haven Mem Pk 12/10/10 |Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary unkel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ONGESTIVE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AORTIC 51 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown برمناط signed by , page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 🗆 No 2 No Division of Vital Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 La Lopatient 2 ER/Outpatient 3 DOA Certification: To Aftert 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

SORDON

CATON AVENUE BALTIMORE MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEE-LLACER IT, MD

NY Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wynema V. Randolph November Day 18,2010 10:03 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😿 F Days Hours Min. (Month, Day, Year) 09/14/1919 **Director** 226-48-8557 Virginia Yrs. Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Rockville 1X Yes 2 No 10e. Street and Number ö 10f. Zip Code er than "natural", or items 23a on the Medical Examiner must be 10g. Citizen of What Country? Funeral 20005 Lumaryn Place 20886 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 🔀 No If Yes, Give hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 7th College (1-4 or 5+) Caregiver Human Services Be 17. Father's Name (First, Middle, Last) should be filed and Mental H is marked of 18. Mother's Name (First, Middle, Maiden Surname) Wyatt Venable Janie Daniel other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Hazel Edwards / Daughter 20005 Lumaryn Place Rockville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place White Oak Grove 11/23/2010 Phenix, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility NE Washington, DC Dunn&Sons 5635 Eads St. 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the secution and the Funeral Director: After this certificate has been signed by the attending physician and mapleted filled in by the funeral director, page 2 should be detached for use as the burian-transit mapleted filled in by the funeral director, Dause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No Pregnant at time of death Month Day Year Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pneumonia 1 Yes 2 No 3 Probably 4 Unknown Pleural Effusions 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? Pleural Infiltrates Yes 2 1 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **X**No Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) (Hospice) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F only one) 29b. Signature and/title of certifier. 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP Rockville MD 20855 6001 Muncaster Mill ROad 31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

State Registrar

32. Registrar's Signature

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	1- For State Registrar			Certifica	ate of L	eath			Re	g. No.			
Physician Medical Examine	Decedent's Name (First, Middle,Last)								2. Date of Death Month Day Year December 1, 2010 3. Time of Death 2100 hrs				
	4a. Facility Name (if no 3605 Moses W	t institution, give st			4b.	City, Town, or Valdorf	Location o		December	4c. County			
Funeral	5. Social Security Numb	ber 6. Sex		In yrs. last birt		If Under 1 Yea		_	8. Date of Birt	h(MM/DD/YYY	vi 9. Birti	hplace (State or	
Director	220-72-82	I IVI	2 X F	4 2	Yrs.	wionths Day	rs Hours	IVIII 1.	01700		Cou	n DC	
any	Usual Residence of De 10a. State 10b	cedent county	110	Oc. City, Town	or Location							10d. Inside City Limits	
., .	MD	Charle					ldor	f				1 XYes 2 No	
death with the Maryland or Items 23a or 28a-f sho must be notified at once.	10e. Street and Number 3605 Mose		Apt. 114			0f. Zip Code 2	0602		10	g. Citizen of W	hat Coun US		
er death with t	11. Marital Status 1 Never Married	2 Married	2. Was Decedent Ev Armed Forces?	ver in U.S.		ecedent of Hi specify Cuba					e - Americ te, etc.	can Indian, Black,	
	3 Widowed	4 XDivorced If		No	1 Y	es 2 X No	specify:			Specify:	Whi	te	
ours after autreal" ramine	15. Decedent's Educa					Usual Occupa of working life				16b. Kind of B	usiness/Ir	ndustry	
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	Elementary/Seconda	ary (0-12)	College (1-4 or 5+)		ashier		ase retired	,,	Reta	ail		
115-0036 filed within 7 all Hygiene, ct of other than it, the Medical Comple	ona 10	st, Middle, Last)	ce		•		18.Mother's	s Name (F hony	irst, Middle, M M . P	aiden Surnam fortei	∍) -		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Commissed by Firneral Director				198 Son 3	b. Mailing A	ddress (Stree	et and Num	ber or Rur	al Route Num	ber, City or To	vn, State,	Zip Code) MD 20707	
re, M 1 and 2 3 Health fitem 2 er traus	20a. Method of Disposi		Removal from State	I .	of Disposition	n (Name of ce place)	metery,		Date	20c. Location	-		
	4 Donation 5	Other Specify:		Final	Jour	ney Cre			/2010	Woodb			
Balti permit. Departm Imports	21. Signature of Funera	ما طاييد	J. VIAIS	uall	1	P(n Rox	₹ 14°	13. Ba	tion S altimo	re.	MD 21203	
Physician Medical	23a. Part T. Enter the di failure. List only o Immediate Cause (Fina	isease, or complica	tions that caused th	e death. Do no	ot enter the	mode of dying	, such as ca	ardiac or re	spiratory arre	st, shock, or he	eart	Approximate Interval Between Onset and	
Examiner	Immediate Cause (Fina or condition resulting in	al disease a. 1 n death) Du	e to (or as a consequ	imonia uence of):	oram,	Alla AC	e Lamin	порпе	in, com	рттсате	d by	Death	
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18760, tificate be ing physic as the bun			23c. If yes, outcome 1 Live birth	or pregnancy	Fetal	death 3	Ectopic	pregnanc	у	Month	D		
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifity within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ladding Certification: To Be Completed by Diversing	1 Yes 2 ✓ No 9	O D Halenaum	4 Pregnant at tir 9 Unknown	ne of death	5 Othe	(Specify)							
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(ecords, The law requires are has been signage 2 should be		-	_						24a. Was a autops perfor	sy		opsy findings available ompletion of cause of	
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the			: To the best of my h				late and pla						
To the Ho within 24 l	one) 2 Me	∽ar	n the basis of examind manner stated.	nation and/or i	investigation			curred at ti	ne time, date a				
	29b 8ignature and title	of certifier	Deals	405	Ð	29c. Licens	se number .M.E.			29d. Date sign December			
(3x pend)	30. Name and address Victor Weedn		npleted cause of dealistant Medical E	_	111 Pe	nn Street, E	Baltimore	e, MD 2	1201				
Stat	e 31. Date filed (Month, I	Day Year) 2010	32 Registrar's	Signature	bare	1	_	-					
Registra	LL LL	J V V LUIU	Coulder	<u> </u>	Car Charles								

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DHMH 17 Rev 7/2009

Registrar

			Please Type or Print in Black		•	
			_ roi	partment of Health and Mo	ental Hygien	e
			Tiegiotai	ertificate of Death	Reg. I	ve 11 1 30010
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Clarence D. Rexroth, Jr.		2. Date of Death December	3. Time of Death 5:30 PM
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
1		34 A	Heritage Harbour Nursing & Rehab	Annapolis		nne Arundel
	Funeral Director		5. Social Security Number 188-03-5212 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 90 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Year 12-28-19	9. Birthplace (State or Foreign Country) Pennsylvania
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	laryla 3a-f s üfied	ect	Maryland Anne Arundel Anna	apolis		1 □ Yes 2 1 No
	or 28	ΙĎ	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	s 23a	Funeral Director	2650 Compass Drive	21401		U.S.A.
	item item ner n		11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces?	 Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
36	after al", or xami	d by	Armed Forces? 1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2 🛣 No If Yes, Give	1 🗆 Yes 2 🏝 No Specify:		Specify: White
9	hours natura ical E	Completed by	15. Decedent's Education 16a. De	cedent's Usual Occupation	16b.	Kind of Business Industry
215	in 72 e. "nan "ı	mc.	Flementary/Seconday (0-12) College (1-4 or 5+)	ive kind of work done during most of working b. DO NOT use retired)	7	
2	d with lygien ther ti	Be C		instrative Consultan		Westinghouse
yland	ld be file Mental H arked ot atic ever	To B	17. Father's Name (First, Middle, Last) Clarence D. Rexroth, Sr.	18. Mother's Name Evelyn		n Surname)
Mar	d 2 shou alth and 27 is m er traum		1	ailing Address (Street and Number or Rural 16 Willow Grove Driv		or Town, State, Zip Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 Removal from State cemetery, o	sposition (Name of Date of Strematory or other place) wn Memorial Pk 12-11		Location - City or Town, State
alti	mit. P partm portal y injur		21. Signature of Puneral Service Licensee			11000071110, 110
m	P P P P P P P P P P P P P P P P P P P		1h he ft set	Witzke Funeral Home 5555 Twin Knolls Ro	s, Inc. ad Colum	bia, MD 21045
			23a. Part 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
- F	nysician/	1	Immediate Cause (Final disease or condition resulting in death)	ive theart tailur	و	Onset and Death
	Medical Examiner		Due to (or as a conseque cof):	Auto, Air	10	10 years
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	ry raviery cuse	460	10 years
١.	d d ansit	Examiner	cause, Enter Underlying Cause (Disease or iinjury that initiated events c.	390.		
-0	be executed sician and burial-transit	E	resulting in death) Last Due to (or as a consequence of):			
	ate be ohysic the bu	dical	d			
687	ertifica ding p	/Me	IF FEMALE: 23b. Was decedent proposit 23c. If yes, outcome of pregnancy			and Date of delivery
Xo	eath certificate t attending phys for use as the t	by Physician/Med	in the past 12 months?	3		23d. Date of delivery Month Day Year
B	the de by the ached	hysi	9 Unknown			
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ds,	quires en sig ould b	ted	Urinary Tract infection	Λ.	1 🗆 Yes	No 3 Probably 4 Unknown
COL	law re nas be e 2 sh	Completed	Dementia		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Be	: The cate I	S			performed?	
ital	sician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes No Hospital: I Inpatient 2 FB/Outpa	26. Place of Death (Check of Other:		
<u></u>	Physer this eral di	e: To	27. Manner of Death 28a. Date of injury 28b. Time	tient 3 DOA 4 Nursing Hom	ne 5 L. Residence Bd. Describe how in	6 Other (Specify)
ou c	nding ath. r: Afte e fune	icat	1 Natural 5 Pending (Month, Day, Year) injur 2 Accident Investigation	y work? M 1 \sum Yes 2 \sum No	•	
Division of Vital Records, P.O. Box 68760	or Atte after de Directo	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 2	8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)
Δ	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 12 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in	vestigation, in my opinion, death occurred at t	he time, date and pla	ce, and due to the cause(s) and manner stated.
	o the vithin 2 o the omple	ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	ge, death occurred at the time, date and place 29c. License number		e(s) and manner as stated. Date signed (Month, Day, Year)
	⊢ ≶ ⊨ ŏ		> XI Calle	123193		
	10		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	51 4	cember 6,2010
	·		Stephen Cillian M) 3169 6	3 raventon St, #201.	Lagenite	LY, IND STOOT
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	·	

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene													
	For State State Registrar			State of	or Maryland / Department of Health and N Certificate of Death				Reg. No.2 0 1 0 38677				
1. Decedent's Name (Firs						TNED				th Day	Year	3. Time of	
Med	ical	JOAN FRANCES 4a. Facility Name (if not institution, give street and nun			SHINER		4b. City, Town, or Location of Death			BER UL	4c. County of Death		Р М
Exami	ner	SAINT	IOSEPH .			TEK		TOWSON				MORE	_
Funera Director	_	5. Social Security N 216-40-	-0634	. Sex 1 ☐ M 2 🔀 F	'. Age (In yrs.	last birthday) 67 _{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 7 – 10 –	Year) 1943	9. Birth Co <i>ur</i> MA	place (State or ntry) RYLAND	Foreign
and show i at	٦	Usual Residence of 10a. State	10a. State 10b. County			ity, Town or Lo	ocation	10d. Inside City Limits					
Maryl: 28a-f otifie	Director	MD					ROS	SEDALE		1 🗆 1			
vith the 23a or st be r		10e. Street and Nu		REEN PLA	CE			10g. Citizen of What Country? U.S.A.					
death v items ier mu	Funeral	11. Marital Status		12. Was Deced	lent Ever in U	.S. 13.	Was Decedent of H	ecify Yes or No-	14. Rad		can Indian,		
within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	ted by	1 Never Mar		d 1 Yes If Yes, Give Year or Dat	2 XNo	1 ☐ Yes 2 X No Specify:				Specify		HITE_	
n "nat	Completed		15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5)			(Give	edent's Usual Occup kind of work done (DO NOT use retired)	king	16b. Kind of Business Industry				
within ygiene. her the		12	12			HOMEMAKER					OWN HOME		
be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) HOWARD KAHL			τ.	18. Mother's N			ne (First, Middle, 1) F:N	∕laiden Surnam	(CLARK)		
should be filed within and Mental Hygiene. ' is marked other tha		19a. Informant's N				19b. Mail	ing Address (Street		-	City or Town,	`	Code)	
e 1 and 2 should be filed within 72 hours tof Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical.				R/ HUSBA			9 WINTE	RGREEN I		ROSEDA			21237
Page 1 annent of Hann, If ite			Cremation 3	Removal from	State	cemetery, cre	osition (Name of matory or other place		- 10	20c. Location	•		,
e inject		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee				22. Name and Address of Facility CVACH / ROSEDALE				FUNERAL HOME			
		1	1211 CHESACO AVE ROSEDALE, MD 21237								37		
Physician.	,	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Onset and Death											
Medica Examine		resulting in death) Due to (or as a consequence of):							\neg				
ed sit	Examiner	Sequentially list or if any, leading to it cause. Enter Under Cause (Disease or	or as a consequence of):										
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cate be physicial the burner of the burner o	edica	d											
ending use as	an/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of				of pregnancy					23d. Date of delivery		
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ysician: is certific director,	To Be												
Attending Physician: The law requires that the death certificate be ar death. ector: After this certificate has been signed by the attending physiciby the funeral director, page 2 should be detached for use as the bu	Certificate;	27. Manner of Dea 1 Natural 2 Accident	injury 28b. Time of 28c. Injury at work? M 28c. Injury at work? 1 Yes 2 No			28d. Describe how injury occurred							
al or Atte s after de l Directo		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					ice 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated of Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									ner stated.		
To the complete th		29b. Signature and	和】				29c. Licens	e number 5344.	5	Dec la	d (Month,	Day, Year)	
		29b. Signature and the off certifier 29c. License number 29d. Date signed (Month, Da) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT T. TURNER M.D. 7601 OSLER DRIVE TOWSON, MARYLAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 09 2010 33. Registrar's Signature											
St	ate	XOBEX 31. Date filed (Mon		URNER 32. Re	M.∆. gistrar's Sign	760 ature	OSLER	DRIVE	100050	~, MA	RYL	AND 2	.1204
Regist		DEC (0 9 2010	Denara	A. 1	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 State of Maryland 2013/10 The Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 4:00 p Am V Stevenson Dec 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Hospice Towson 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Davs Hours OCT. 4, Year 925 Maryland 85 214-22-1551 Director Usual Residence of Decedent or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County filed within 72 hours after death with the Maryland Director MD Baltimore Baltimore 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10a. Citizen of What Country? ò ural", or items 23a o Examiner must be Funeral 4515 Ambermill Road 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates SpecifyWhite "natural" Completed 3 Widowed 4 ☐ Divorced the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker Baltimore Co unty 9th and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Robert R. Carrick Edith Luhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bauer /daughter 4515 Ambermill Road Baltimore MD 21236 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State SacredHeartofJesus 12/6/10 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 MAce Ave. 21. Signature of Funeral Service Licenses Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that cause in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ **PNEUMONIA** disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 X No signed by the atte Pregnant at time of death Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an page 2 s has autopsy certificate Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 🗶 No ျ 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) HOSPTCE 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury work?
1 Yes 2 No 5 Pending Investigation Accident 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tipe 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

DECEMBER

STEVENSON

2300 DULANEY VALLEY RD.

32. Registrar's Signatu

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

31. Date filed (Month, Day, Year)

nfc 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	ate of Marylar				Mental Hygie	ene		00670	
1. Decedent's Name (First, Middle, Last)				Cer	tificate of D	veath	1	g. No.	1 U	30013		
Physician/			1. Decedent's Name (First, Middle, Last)		_			2. Date of Death Month	Day oc	Year	3. Time of Death	
	Medic	al	Salvatore		Sa	<u>batino</u>		December 1)10°	11:45 P ^M	
	Examin	er	4a. Facility Name (if not institution, give street ar	na number)			Location of Death		4c. County			
		25	Gilchrist 5. Social Security Number 6. Sex	7. Age (In yrs. i	last hirthday)	If Under 1 Year	ISON If Under 24 Hrs.	8, Date of Birth	l Bal	timor	ece (State or Foreign	
	Funeral Director		217-09-1386		Yrs.	Months Days	Hours Min.	Oct. 4	°°°1918	Count	yland	
	-	Ġ.	Usual Residence of Decedent	1 12				1000. 14,	1710	LICIL	yzana	
	and shov	ō	10a. State 10b. County	10c. Cit	ty, Town or Loc	ation				10	d. Inside City Limits	
	Maryl 18a-f tifie	rec	Maryland Baltimore	<u>.</u>	Owin	gs Mills					1 ☐ Yes 2X No	
	the I		10e. Street and Number	•		10f. Zip Code		10	g. Citizen of \	What Count	ry?	
	s 23 nust l	Funeral Director	4814 Stone Shop Cir	cle		2111	17		U.S	S.A.		
	death item item	Ξ	11. Marital Status 12. Wa	s Decedent Ever in U. ged Forces?		as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No-		e - America k, White, e		
9	after ", or camir	by	a D var. I d D Di I I I I I Y	ged Forces? Yes 2 No es, Give	1	☐ Yes 2X No		,	Specify:			
3	ours and intural	etec	3 ☐ Widowed 4 ☐ Divorced Yea	er or Dates.						WN1		
ဂ်	72 ha n "na Nedia	nple	(Specify only highest grade com	pleted)	(Give k	ent's Usual Occupa ind of work done d) NOT use retired)		king 1	6b. Kind of B	usiness Indi	ustry	
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Ö	Hygi ent,		17. Father's Name (First, Middle, Last)		Haco	Dody Repe		ne (First, Middle, Ma				
<u>a</u>	be fi ental rked ic ev		Mario	Sabatino			M	laryanne	(Guglui	zza	
Maryland 21215-0036	nould Ind M s mal		19a. Informant's Name/Relationship (Type, Prin		19b. Mailin	g Address (Street a		al Route Number, C				
Σ	d 2 statt a alth a alth a 127 is sr tra		Mary S. Sabatino	Wife				e Owings				
<u>6</u>	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. The of Health and Mental Hygiene. The of Health and Mental Hygiene. The masked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	20h I	Place of Disnos	sition (Name of			0c. Location -			
Ĕ	Page nent ant: I		1 Burial 2 Cremation 3 Remove 4 Donation 5 Xother (Seption on	nent Dui	laney y emorial	ardens	12-9-	2010	Γimoniα	ım. N	Maryland	
Baitimore,	permit. Page 1 a Department of I Important: If its any injury or of		21. Service Licensee		22.	Name and Addres	s of Facility Ruc	k Towson	Funera	al Hon	ne, Inc.	
ם	20 E # 9	2	tank Hagan			50 York I		wson, Mar		21204	+	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
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_	sit sid	nin.	cause, Enter Underlying	uence ot):								
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POX	leath e atte d for	sicia	1 Ves 2 No	Live Birth 2 L Feta Pregnant at time of Unknown		Other (specify)	y		Mo	nth [Day Year	
5	the c by th	Physician/Me	9 🗆 Unknown									
Z.	requires that the death certifical been signed by the attending p should be detached for use as t	by	Part II. Other significant conditions contributing	ng to death but not res	sulting in the ur	nderlying cause give	en in Part I.	11			e cause of death?	
g,	quire en si	ted				-		1 Yes	2 ∐ No	3 ∐ Proba	ably 4 🗆 Unknown	
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Vital Records,	cran: ertific ector,	Be	25. Was case referred to medical examiner?				ace of Death (Chec		1		45	
2	Physical this call dire	2	1 Li Yes 2 Li No	1 Inpatient 2 Inpatient 2	ER/Outpatient 28b. Time of		4 ☐ Nursing Ho	ome 5 🗆 Residend	/		Wospile	
10 L	Jing F n. After funer	ate	1 № Natural 5 Pending	(Month, Day, Year)	injury	28c. Injury work? M 1	rat ? Yes 2 □ No	28d. Describe how	injury occurre	ed		
<u> </u>	deatl deatl stor: y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	Place of Injury - At ho	ome farm stre		tes Z L No	28f Location /Stree	et and Numbe	or Or Pumi F	Poute Number	
DIVISION	after after Dire		4 Homicide determined	ot, rastery, emos		ff. Location (Street and Number or Rural Route Number, City or Town, State)						
4	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier Certifying Physician: To									
	he Ho in 24 he Fu iplete	Mec	(Check 2 Medical Examiner: On only one) 3 Certifying Nurse Pract									
	With Corr		29b. Signature and title of certifier	0 4 A		29c. License	number		d. Date signed			
* An an and							1) 58 503 Vee			enter 6 2010		
	5		30. Name and address of person who complete	d cause of death (Item	1 23a) (Type, Pr	int)	1000		M co. I			
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signa	0 0 /	14/0	valus	01 12	NOSON	U IVC	1/	
	Registra		DEC 0 9 2010 Pener	1 A. A	arke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Jim E. Starr 2010 10:45 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Manor Care - Ruxton Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 ☐ F 543-56-6603 Director 7/16/1945 Oregon Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1029 Breezewick Road 21286 U.S.A.

14. Race - American Indian,
Black, White, etc. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department Defense College (1-4or 5+) Elementary/Secondary (0-12) Sergant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eradmus Starr Susan Davies 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Starr / Wife 1029 Breezewick Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Serv. Corp. 12/9/2010 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Nel 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cinnhusis liver **Physician** /Medical Due to (or as a consequence of): Examiner Cardiomnora Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Congestive sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buriar Hyper tension Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Inknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 12-09-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

7505

OSLER

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MRIARA

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Jark

State Registrar

DHMH 17 Rev 7/2009

barker

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OSLER DRIVE TOWSON, MARYLAND 21204

Mi.

IM

M.D.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PICHARD

DEC 0 9 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ 2010 11:55 P M Archie Thomas Satterfield Dec. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice Care If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number Month, Day, Y **Funeral** 1^{ear)}1930 Country) Days Hours Min **™** M 2 □ F 80 Sept. Director Yrs. 193-22-4646 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 ☐ Yes 2 No MD Baltimore Reisterstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ral", or items 23a or Examiner must be Funeral with 1 USA 21136 12605 Worthington Ridge Rd. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: White permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mechanical Equipment Sales Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 9 Isabel Fulton Archie Taylor Satterfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12605 Worthington Ridge Rd., Reisterstown, MD 2113 Rachel Satterfield/wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Garrison Forest Vet.Cem. 12/15/10 Garrison Forest, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 Michael 3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between webs mhs Onset and Death Immediate Cause (Final Physician/ months disease or condition resulting in death) / Medical equence of) to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a detached f 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law r
 24 hours after death.
 Funeral Director: After this certificate has b page 2 s autopsy performed' 1 Yes 2 No Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 At Other (Specify) W.S. C.L. P. Hospital: 1 Yes 2 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu cember 6 2010 address of person who completed cause of death (Item 23a) (Type, Print) W. Charles ST TOWSON NO AMeris M) 6701 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 0 9 2010 Registrar

DHMH 17 Rev 7/2009

			Please	State of Maryland				_	_	
		_	For State Registrar	- Clute of Marylan	•	tificate of L		, ,	leg. No 0 0	38683
	Physicia Medic	al	1. Decedent's Name (First, Middle, Las ATHERINE	ViRginia	5	mith		2. Date of Dear Month Decemb	er & 201	
-	Examin	er	4a. Facility Name (if not institution, give	street and number)		1 10 " /	Location of Death		4c. County of Dea	ath
	Funeral Director		xx0-2x-1010	ex 7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	3,1927 (La	irthplace (State or Foreign ountry)
	f show	tor	Usual Residence of Decedent 10a, State 10b. County		y, Town or Lo	,				10d. Inside City Limits
	he Mary or 28a-i notifie	Director	10e, Street and Number	BA.	Him	10f, Zip Code			 10g. Citizen of What C	1 Yes 2 □ No Country?
2	th with t ns 23a must be	Funeral	2/26 W. Faien	T	Las	2126			LISA	
. X 9	fter dear , or iter	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 Ses 2 No	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖽 No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
atherin 215-0036	hours al natural" ical Exa	leted	3 ★ Widowed 4 □ Divorced 15. Decedent's E		16a, Dece	dent's Usual Occup	ation		16b. Kind of Business	
7at 1215	thin 72 l ene. than "r he Med	Completed	(Specify only highest gra	ade completed) College (1-4 or 5+)	Ìife. D	O NOT, use retired)	during most of work	ing	OWN HE	ome
nd 21	filed wi tal Hygid of other event, t	To Be (17. Father's Name (First, Middle, Last)		Pame	25776.			Maiden Surname)	
Smth, e , Maryland	nould be nd Meni s marke umatic	•	19a. Informant's Name/Relationship (7)	ク 4 d ype, Print)	1 19b. Mailii	ng Address (Street	and Number or Rur	LIP-FOR al Route Number,	2 d City or Town, State, 2	Zip Code)
S Z	and 2 st Health a em 27 is ther tra		DENISE BOWER 20a. Method of Disposition	05-Granddaughte		Winfor			se maryli	
Saltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1	Removal from State	emetery, <i>j</i> crer	matory or other place Memesical	ce)	Date 3 2010 F	20c. Location - City of	ARY/And
Balti	permit. Departr Importa any inju		21. Si natur of Funeral Service Licens				ss of Facility	chools!	BAHO, MO	21229
			23a. Part 1. Erner the disease, or com shock, or heart failure. List only o Immediate Cause (Final	plications that caused the death	h. Do not ent		/	or respiratory arre	est,	Approximate Interval Between
	Ph_sician/ Medical	0 18	Immediate Cause Final disease or condition resulting in death)	a. Due to (or as a consequ	Sclich uence of):	other Ne	east)	scasc		Sonset and Death
1	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ	ience off.					
11)8	ecuted and I-transit	Examiner	Cause (Disease or iinjury that initiated events	c						
0	oe ex ician ouria	g	resulting in death) Last	Due to (or as a consequent	uence of):					
68760	eath certificate b attending physic I for use as the b	/Med	IF FEMALE:	23c. If yes, outcome of pregna	ıncv			***************************************	23d. Date of d	leliven
Вох	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Physician/Medio	23b. Was decedent pregnant in the past 12 moriths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3	Cther (specify)	су		Month	Day Year
P.O.	requires that the de been signed by the should be detached		Part II. Other significant conditions c	ontributing to death but not res	ulting in the u	underlying cause gi	ven in Part I.			to the cause of death?
of Vital Records,	requires been sig should b	Completed by						1 L Y	n 24b. Were a	Probably 4 Unknown
Reco	The law ate has page 2 :	Somp						autop	sy prior to med? _ death?	c completion of cause of es 2 No
/ital	sician: certific irector,	a	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2💢	FR/0 4	Oth	lace of Death (Chec		ence 6 🗌 Other (Spe	- 17. \
Jo	ng Phy fter this ineral d	ite: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time or injury	f 28c. Injur work	y at k?		ow injury occurred	(CITY)
Division	or Attendi after death. Director: A I in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho			Yes 2 No		treet and Number or R	lural Route Number,
Div	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to			building, etc. (Specify,		occured at the time	e, date and place a	City or Town		stated.
	To the Hos within 24 h To the Fun completed	Medical	(Check Medical Examonly one) 3 Certifying Nur	iner: On the basis of examination se Practioner: To the best of my	n and/or inves	stigation, in my opini- death occurred at th	on, death occurred a ne time, date and pla	at the time, date ar ice, and due to the	nd place, and due to the cause(s) and manner a	e cause(s) and manner stated. as stated.
	7 wit		29b. Signature and title of certifier Well	uff the		29c. Licens	43375		29d. Date signed (<i>Mon</i>	yn, Day, Year) 20/0
	(0		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Pint) Ave (Suited	03 /hu	Etimore,	111) 21209
	Sta	te	31. Date filed (17) 17(Coa) 19(1) 201	32, Registrar's Signat	ture far	Red		- (/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 26, 2010 Year Physician/ 9:30 A M CHRISTINE MARIE SKOWRUNSKI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL Brooklyn Park 306 PANORAMA WAY Under 1 Year If Under 24 Hrs 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Country 1 M 2 F Months Min. JULY 7, Day Year Hours 55 219.64.9955 Director Usual Residence of Decedent 10a State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 Yes 2XX No BROOKLYN PARK ANNE ARUNDEL MD 10f. Zip Code 9 10e Street and Number 10g. Citizen of What Country? 23a Funeral USA 21225 306 PANORAMA WAY items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed ForceXX Black, White, etc. 1 Never Married 2 Married ò þ should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 1 🗆 Yes 2XX No If Yes, Give Year or Dates Specify Specify: "natural", 3 Widowed 4 Divorced WHITE Completed event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE CITY SCHOOLS PRICIPLE 12 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental is marked o ည V. JUNE SKOWRUNSKI STANLEY J. SKOWRUNSKI other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 306 PANORAMA WAY BROOKLYN PARK, MD 21225 SISTER JOYCE POPP 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place) 1 XXBurial 2 XXCremation 3 - Removal from State GLEN BURNIE, MD **GLEN HAVEN CEMETERY** DEC 3, 2010 4 Donation 5 Other (Sp Signature of Funeral Service Lice TINK FUNERAL HOME, P.A. **CREGORY** M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 complications that caused the death. Do not enter the mode of dying, such as cardiac or respir tory arrest Approximate Interval Between beart failure. List only one caus on each line nset and Dear Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that initiated events resulting in death) Last Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 XXIo Day Month Pregnant at time of death 1 Yes 2 I g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably XX Unknown Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to death? autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2XX No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? XX 5 Residence 6 Other (Specify) 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occ urred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

15

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CALVIN CARTER 4710 PENNINCTON AVE CURTIS BAY, MD 21226

D001459

DECEMBER 1, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Lettie B. Smith Dec 2010 5:35P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie 410 Maple La If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7, Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Nov 25, 1916 1 M 2 KXF Days Hours 94 Director 218.28.5091 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State items 23a or 28a-f sho her must be notified at Director filed within 72 hours after death with the Maryland 1 Yes 2 XNo Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21061 410 Maple La 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2XX No ori by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 XWidowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kInd of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Cashier's Office Hutzlers Dept. Store Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Page 1 and 2 should be Lilly Franklin Frank Braun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 Stewart Ave, Glen Burnie, MD 21061 Debra Billings Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Dec 9, 2010 Glen Haven Cemetery Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility
Fink Funeral Home, P.A. 21. Signature of Funeral Service Gregor M01148 426 Crain Hwy S... Glen Burnie. o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the Part 1. Enter the disease, shock, or heart failure. List Immediate Cause (Final Ph_sician/ disease or condition resulting in death) tens. Medical **Examiner** Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying signed by the attending physician and do be detached for use as the burial-transit Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown page 2 should be detached g Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N 1 Yes 2 No this certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after death.

I Director: After the in by the funeral Certificate: work 1 Natural 5 Pending 1 Tyes 2 🖵 No Investigation Accident 6 Could not be Suicide within 24 hours after de To the Funeral Director completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie | Medical Examiner: On the basis of examiniation allower in reasonable | Certifying Nurse Practioner: To the best of my knowledge, death occiurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

State Registrar 31. Date filed (Month, Day, Year,

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 2010 5:20 **Physician** Catherine November 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HRC Manor Care Baltimore Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 6. Sex 5. Social Security Number Days **Funeral** Hours 1 ☐ M 2 🔽 F Feb 24, Maryland 79 213-28-4138 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland a or 28a-f show the notified at 10a. State 1 ☐ Yes 2 No Director Towson Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 items 23a 305 E. Joppa Road #306 USA r than "natural", or items 23a the Medical Examiner must I by Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. ☐ Yes 2 XNo f Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 💢 No Specify: white 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) food industry waitress 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be and Mental F Mary Catherine Gilmore John Thomas Kline 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21093 32 Edgemoor Road Timonium, MD Pages 1 and 2 nent of Health a Donna Gillespie/daughter Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signaldre of Funeral Service State Anatomy Board 655 W. Baltimore Street 23a. Part. Enter the diseas, or complications that caused the death. shock, heart failure. List only one cause on each line. 21201 Baltimore, MD Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Com Cer week **Physician** /Medical Due to (or as onsequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by Certification: To

Catherine Schmid P.O. Box 68760, Division or Vital Records,

Baltimore, Maryland 21215-0036

-24-

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Dem en t	n A	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown						
		24a. Was an autopsy indings available prior to completion of cause of death? 1□ Yes 2 No 1□ Yes 2 No						
25. Was case referred to medical	26. Place of Death	26. Place of Death Check onl one						
examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		if. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of my knowledge, death occurred at the time, date and place, ar miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)						

29d. Date signed (Month, Day, Year)

Bellona Lane #216, Towson, MD 21204

November, 26, 2010

State Registrar

Medical

29b. Signature and title of ce

ho completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		artment of H rtificate of L		•	giene Reg. No.	10	38687				
	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of De Month	ath Day	Year	3. Time of Death				
	/Medi		Harvey Lewis Sax			г—-		Novembe		2010	3:35 P M				
	Examir	er	4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Deal	th		4c. County of Death Worcester					
and a			42 Wood Duck Driv 5. Social Security Number 6. Se		last hirthday)	Berlin	If Under 24 Hrs	8. Date of Bir							
	Funeral Director			7M 2□ E	83 Yrs.	Months Days	Hours Min		ay, Year) - 1927	Mas	place (State or Foreign ntry) sachusetts				
			Usual Residence of Decedent		0.5			5 dir 2 5	,						
	rylan show	_	10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits				
	8a-f s	cto	MD Worcest	er	Berlin						1 □ Yes 2 □ No				
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?				
	s 232	era	42 Wood Duck Dri	.Ve 12. Was Decedent Ever in U.	C 12.1		1811	Ennaite Van or No	USA	noo Amori	ean Indian				
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Idem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □Yes 27 No	Specify:	to Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: white					
5-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occupa	ation during most of wo	rkina	16b. Kind of E	Business/Ir	ndustry				
2121	ithin ne.	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)		st healthcare						
2	lled w Hygie ther th		12 17. Father's Name (First, Middle, Last)	5+		CIIIICai		her's Name (First, Middle, Maiden Surname)							
and	d be fi	Be	Cooile Conjuing Signle												
Maryland	2 should be filed within 7 n and Mental Hygiene. Is marked other than "raumatic event, Inc. Med.	၉	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Street a	and Number or F	lural Route Numb	er. Citv or Towi	n. State. Zi	p Code)				
	1 and 2 s Health a em 27 is ther trau		Shirley Saxton/s		42	Wood Duc	k Drive	Berlin,	MD 21	811	•				
altimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	20b. F Removal from State	Place of Dispo cemetery, crer	osition (Name of matory or other place	e)	Date	20c. Location	- City or T	own, State				
Balti	permit. Page Department of Important: If any injury or once.		21. Sign dure 1 Fu eral Ser ice licens Ron 1 1	200		Name and Addres Ate Anato Altimore,			Baltim	nore S	Street				
			23a. Part 1. Enter the disease, or comp	lications that caused the death					ırrest,		Approximate Interval Between				
-	Physician		shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)												
	/Medical		resulting in death)	Due to (or as a conseq							1				
	Examiner		Sequentially list conditions	b											
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	uence of):										
_	and I-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):										
68760,	icate be executed physician and the burial-transit	ia E	Q.												
687	ificate g physis the	edical		a											
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	ıl death 3 🛭	Ectopic pregnancy Other (specify)	у		I	ate of deliv	very Day Year				
σ.	that the ned by t detach		Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?				
rds	quires in sign ald be	d by						1 🗆	Yes 2 No	3☐ Pro	bably 4 ☐ Unknown				
of Vital Records,	law requir as been s 2 should	Completed						24a. Was		. Were aut	opsy findings available				
Ä	The Is	lmo						auto perfo 1 □ Yes	ormed?	prior to co death? 1 ☐ Yes	ompletion of cause of				
ita	sician; The certificate rector, pag	Be C	25. Was case referred to medical				26. Place of De	ath (Check only		1 🗆 163	2,0210				
†	nysic nis ce direc	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Othe	er: 4 Nursing	Home 5 ₹ Res	idence 6 □O	ther (Spec	ify)				
0 0	Attending Physician: r death. ector: After this certific. by the funeral director, I		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	f 28c. Injury Work	y at	28d. Describe	how injury occu	urred					
sio	death.	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No								
Division	or Atten after deat Director:	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		eet, factory, office		28f. Location (City or To	Street and Nun wn, State)	nber or Rui	ral Route Number,				
	Hospital or 24 hours afte Funeral Dir tely filled in I		29a. Certifier 1 Certifying Phy	/sician: To the best of my kno	nwledge dest	h occurred at the tir	me date and place	and due to the	cauca/a\ and	manner ce	etated				
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by th	Medical		iner: On the basis of examina and manner stated.											
	Fo the within 2 Fo the comple	Me	29b. Signature and title of certifier			29c. License	e number	T	29d. Date sign	ned (Month	, Day, Year)				
	- > E 0		\	D.O.		H44	828		12/1	110					
			30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type,	Print)				.)					
			Brookellen	Kider, DU	1. 314	Frence	· Au	Sult 6	403 B	Dell	mo 2181				
	Sta		31. Date filed (Month, Day, Year)	92. Registrar's Signa	ature.	1									
	Registi	al	RFC 0 9 2010	/ beeck B.	SEP COUNTY	-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State	State of Man				d Mental Hy	giene			
			Registrar	4)	Cer	tificate of L	Death		Reg. No.	0 -38688		
	Physicia	in/	1. Decedent's Name (First, Middle, Las	•				2. Date of Dea Month	Day `	Year 3. Time of Death		
	Medic		Patricia M. Scal 4a. Facility Name (if not institution, give			4b. City, Town, o	r Location of Do	<u>Decemb</u>	4c. County o	10 12:30 AM		
	Examin	ier	Stella Maris Hos				nium	aui	-	imore		
	Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 H		h	9. Birthplace (State or Foreign		
	Director		212-22-7900	□ M 2 🗓 F	87 Yrs.	Months Days	Hours M	sept 7	1923	Maryland		
	oor at] _	Usual Residence of Decedent 10a, State 10b, County	10	Oc. City, Town or Loc	cation	-			10d. Inside City Limits		
	arylan a-fsh fied	Director			-	te Hall				1 🗆 Yes 2 No		
	or 28		MD Baltimo	ore	MIIT	10f. Zip Code			10g. Citizen of Wh			
	with t	eral	4169 Norrisville	Road			21161		USA			
	leath items ier mi	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin?	(Specify Yes or No-		- American Indian,		
၁	after o	ğ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Yes 2 No		orto Filouri, ctc.,	Specify:	, White, etc. white		
3-003p	ours a atural cal Eo	Completed	3 Widowed 4 □ Divorced 15. Decedent's Ed	Year or Dates.		lent's Usual Occup						
<u>.</u>	n 72 h	ם	(Specify only highest gra	de completed)	(Give F	kind of work done (O NOT use retired)	during most of w	vorking	16b. Kind of Bus	iness Industry		
7	within giene. er tha the l		Elementary/Seconday (0-12)	College (1-4 or 5+)	1	omemaker			own h	ome		
2	filed al Hyg d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	Name (First, Middle,	Maiden Surname)	-		
yland	ild be Ment narke	욘	Vincent Paul Mu	rphy		_	Ray	Ray Murray				
Nar Nar	shou n and 7 is n		19a. Informant's Name/Relationship (Ty Carey Schenke1/da					Rural Route Number ad White				
a,	and 2 Health em 2: ther t		20a. Method of Disposition		20b. Place of Dispos		iiie ko			21161 Dity or Town, State		
<u></u>	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	_	1 🗌 Burial 2 🗌 Cremation 3 🗌	Removal from State		natory or other place	ce)	Date	200. Location - C	bity or Town, State		
Бащто	nit. Pa artme ortan injun		4 Donation 5 Other (Specifical Service License		. 22	Name and Addre	ss of Facility	1 655 IJ	Poltim	ore Street		
Ď	Dep Imp any onc		21. Signature of Euneral Sarvice Licens	Wade Wirec		tate Ana altimore	-		• Daitin	ore street		
			23a. Part 1. Inter the disease or comp shock, or heart failure. List only or				-		est,	Approximate Interval Between		
~ F	hysician/		Immediate C use (Final disease or condition	CARDIOM	YOPATHY					Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a co								
		-e	Sequentially list conditions,	b. Due to (or as a co	unacquanca of:							
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a co	insequence oi):					92		
	xecut n and al-trar	EX	that initiated events resulting in death) Last	Due to (or as a co	ensequence of):							
3	icate be executed physician and sthe burial-transit	edical		d								
00	ifficate ng phy as th	Med	IF FEMALE:									
Р К	th cer tendii or use	Physician/M	23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐	Fetal death 3	Ectopic pregnanc	у			of delivery		
Š ·	e deat the at hed fo	sic	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 ☐ Pregnant at tin 9 ☐ Unknown	ne of death 5 ∟	Other (specify) _			Mont	h Day Year		
<u>;</u>	nat the od by detacl		Part II. Other significant conditions co	ontributing to death but n	ot resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?		
'n	ires th	d by						_ 1 🗆 Y	es 2 No 3	☐ Probably 4 ☐ Unknown		
records,	v requ	Completed	3					24a. Was a	an 24b. We	ere autopsy findings available		
ָטַ טַ	he lav :e has age 2	mo di						autop perfor	med? de	or to completion of cause of ath? ☐ Yes 2 ☐ No		
E 1	an: T tifficat tor, p	Be C	25. Was case referred to medical			26. PI	ace of Death (C	1 🗌 Yes heck only one)	ZXJNOJ IL	res _2 L_ No		
NICAL NICAL	nysici lis cel direc	TO E	examiner? 1 Yes 2 No	Hospital: 1 🗀 Inpatient	2 ER/Outpatien	t 3 🗆 DOA Othe	er: 4 🗆 Nursinç	Home 5 Resid	ence 6 \ Other	(Specify) HOSPICE		
5 '	ng Pl		27. Manner of Death 1 X Natural 5 Pending	28a. Date of injury (Month, Day, Ye	28b. Time of injury	28c. Injury work	?	28d. Describe ho	ow injury occurred			
VISION	tendi Jeath tor: A the fu	iiį	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 No					
2 :	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	et, factory, office		28f. Location (S City or Town		or Rural Route Number,		
ב כ	spital		29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge, death o	occured at the time	, date and place	e, and due to the cau	ise(s) and manner	as stated.		
:	n 24 h	Medical		ner: On the basis of exam e Practioner: To the best						o the cause(s) and manner stated. ner as stated.		
1	Vithi Vithi Com	_	29b. Signature and title of certifier	0.0		29c. License	e number	:	29d. Date signed (Month, Day, Year)		
	1		CHAMIL	2 ANT		17/14	4792		12/1	2010		
			30. Name and andress of person who c		55 HI							
			JACKIE JONES, CR 31. Date filed (Month, Day, Year)	NP 2300 DU 32. Registrar's	LANEY VAL	LEY RD.	TIMONI	UM, MD 21	093			
	Stat	(6)	DEC 0.9 2010	52. Hogistial S		•						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Dorothy B. Sensibaugh 12 53 PM DECEMBER OI 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ST- AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign 3irthplac Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 □ M 2 🕱 F 09-28-1940 213-36-6588 70 Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 1 ☐ Yes 2X No Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7550 Wigley Avenue 20794 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ∐Yes 2NONo Specify: Specify: White 3 Widowed 4XXDivorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Reading Specialist Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy B. Campbell Walter Carl Wieland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2610 Turf Valley Road, Ellicott City, MD 21042 Susan B. Masciarelli - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Park | 12-06-2010 | Elkridge, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash Blvd., Elkridge, MD 21075

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other the any Injury or other traumatic event, the once.

Physician

/Medical

Examiner

10a, State

MD

Funeral

Director

ral", or items 23a or 28a-f shore Examiner must be notified at

Directo

Funeral

þ

Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Box 68760,

ORO THY P.O.

SENSIBAUGH Vital

Division of

s been signed be should be deta I or Attending Physician: after death.

23a. Part 1. Inter the disease, or of shock, or heart failure. List of	omplications that caused the death. Do not enter nly one cause on each line.	he mode of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between							
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC BR	EAST CARCINOMA		Onset and Death							
roodiing in dealin	Due to (or as a consequence of):										
Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):	b. Due to (or as a consequence of):									
that initiated events resulting in death) Last	c. Due to (or as a consequence of):										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑️️ Mo	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ E	ctopic pregnancy ther (specify)		23d. Date of delivery Month Day Year							
Part II. Other significant condition	s contributing to death but not resulting in the unde	rlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available							
			autopsy performed? 1 Yes 2 No	prior to completion of cause of death?							
25. Was case referred to medical examiner?		26. Place of Death	·								
1 Yes 2 1√No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☐ Nursing Hon	ne 5 Residence	6 ☐ Other (Specify)							
27. Manner of Death 1 Natural 5 Pending 2 Accident investiga		28c. Injury at Work? M 1 Yes 2 No	8d. Describe how injur	y occurred							
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		factory, office 2	8f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)							
29a. Certifier 1 ☑ Certifying (Check only 2 ☐ Medical E	Physician: To the best of my knowledge, death o xaminer: On the basis of examination and/or inves and manner stated.	ccurred at the time, date and place, a tigation, in my opinion, death occurred	and due to the cause(s ed at the time, date and	a) and manner as stated. d place, and due to the cause(s)							
29b. Signature and title of certifier	00 1/2	29c. License number	29d. Da	te signed (Month, Day, Year)							
Me Me	Priyaa Viswanathan.	P25483	C 01 2010								

12

State

Registrar

900s, Caton Avenue,

32. Registrar's Signature

back

Baltimore, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Priyaa Viswanathan,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2016 025 Physician/ VORMAN Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 ★ M 2 □ F Days Hours Min. 0171471919 Country) 91 MD215-10-5978 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 X No BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 21208 USA 4203 COLONIAL ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married ò 1 Yes If Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: han "natural", Medical Exan Specify. WHITE 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than ' College (1-4 or 5+) Elementary/Seconday (0-12) ACCOUNTING ACCOUNTANT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fishers is marked o ည should be SHEVACH SOLLOD ANNA **JOSEPH** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 4203 COLONIAL ROAD, BALTIMORE, MD MARLEEN SOLLOD/WIFE Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
HAR ZION TIFERETH
ISRAEL CEMETERY 1 X Burial 2 Cremation 3 Removal from State 12/8/2010 4 Donation 5 Other (Specify) BALTIMORE, MD 22. Name and Address of Facility Signature of Juneral Service Licens SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD_ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a s the burial-1 Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 Yes 2 L g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 TYes certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this within 24 hours after death.

To the Funeral Director: After th
completed filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Investigation Accident 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Month Debra Ann Todd 10:15 P M December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Orchard Beach Anne Arundel 717 Hilltop Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Month, Day, Year 217-72-5722 52 Marvland 14 Director TAN 1958 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ä Director notified 1 🗆 Yes 2 🔀 No MD Anne Arundel Orchard Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a or ner must be r Funeral 717 Hilltop Road 21226 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Examiner Armed Forces Black, White, etc. 0 þ 1 Never Married 2 X Married ☐ Yes 2 X No nours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 be Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event "the "coce." Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Albert Bussev Fannie Redin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelly M. Byczynski, daughter 2157 Lake Drive Pasadena. Marvland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 12/09/10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ung cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year 4 Pregnant at time of death g Unknown Yes 2 No has been signed by the a e 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No page 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 🗌 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MSRAJAPALNE M.D. 29d. Date signed (Month, Day, Year) D0057465 12/9/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N S Raj NPAKS MID 2835 Smith Av. 5-203 Balhmore, MD 21209 N.S. Rajnpakse, M.D

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

10-09302 Troy Thomas iny or 28a-f show MD 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 010 38692 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Month Day December 3, 2010 2324 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samartian Hospital Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) Months Days Hours Min Director 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No than "natural", or items 23a or 28a-f sho edical Examiner must be notified at once, Pages 1 and 2 should be filed within 72 hours after death with the Maryland thent of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 00 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Armed Forces? White, etc. the Medical Examiner must Yes If Yes, Give Year Yes 2 No specify: Specify: 3 Widowed 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th t: If item 27 is marked other other traumatic event, the Me 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) dulara 21217 Inoma 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 2 Cremation 3 Important; Donation 5 Other Specifi 23. Name and Address of Facility Approximate Interval ease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** List only one cause on each line Between Onset and /Medical Death a Gunshot Wound of Chest iate Cause (Final disease ≟xaminei or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - transi Division of Vital Records, P.O. Box 68760, rial or Attending Physician: The law requires that the death certificate be executed Physician/Medical **AMENDED** UNPENDED 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 V No 3 Probably 4 Unknown Completed ficate has been si 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 🗸 Yes certificate Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. director, Be examiner? Other Nursing Home 5 Residence 6 Other: this 1 Yes After Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Dec 3, 2010 Subject shot Natural 2315 hrs 1 Yes 2 ✔ No Pending the To the Funeral Director: 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 1900 East 30th Street, Baltimore, MD determined (Specify) Outside 4 Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) December 4, 2010 O.C.M.E.

DHMH 17 Rev 1/2001 OCME 2006

State

Registra

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

OCME

Assistant Medical Examiner 32 Registrar's Signat

Rosema

Donna M. Vincenti, MD

		4	For State	State of Maryland /		rtment of H			iene _{eg. No} 2 0 1 (38693	
			Registrar 1. Decedent's Name (First, Middle, Last,		007	inouto of B	- Cutin	2. Date of Deatl	h	3. Time of Death	
	Physicia							Decembe	r 3, 2010	10:00 P.M	
	Medic		Mary Ann Lanzoni Aa. Facility Name (If not institution, give s			4b. City, Town, or	Location of De		4c. County of E	Peath	
	Examin	er	7228 Old Gate Roa			Rockvil:	le		Montgom	ery	
*	Funeral		. Social Security Number 6. Se	7. Age (In yrs. last bir	thday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Birth	Year) 9.	Birthplace (State or Foreign	
	Director		048-30-3795	□ M 2 XF 71	Yrs.	Months Days	Hours Mi	in. (Month, Day August 8,	1939 Co	nnecticut_	
	3		Usual Residence of Decedent							10d. Inside City Limits	
	/land f sho ed at	ţ	10a. State 10b. County	10c. City, Tow	vn or Loc		411 <u>-</u>			1 X Yes 2 □ No	
	Mar.		Maryland Montgome	ry		Rockv	TITE		log. Citizen of Wha		
	h the	alD	10e. Street and Number			208.	5 2		United S		
	h wit	Funeral	7228 Old Gate Ro	ad . 12. Was Decedent Ever in U.S.	12 1			(Specify Yes or No-		American Indian,	
	deal r iter iner		11. Marital Status 1 ☐ Never Married 2 🛣 Married	Armed Forces?	- 1			(Specify Yes or No- erto Rican, etc.)		Vhite, etc.	
36	al", o	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 No	Specify:		Specify: V	Mhite	
21215-0036	hours natur ical l	Completed	15. Decedent's Ed	ucation 16a	a. Deced	lent's Usual Occupa	ation	vorkina	16b. Kind of Busin	ess Industry	
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pu	filed al Hy d oth	o Be	17. Father's Name (First, Middle, Last)					Name <i>(First, Middle, N</i> La Pyskaty	Maiden Surname)		
yla	ld be Ment arke	인	Edward Lanzoni								
Maryland	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "I traumatic event, the Med		19a. Informant's Name/Relationship (Ty	_				Rural Route Number,			
2	und 2 lealth im 27 her tu		Edmund C. Tramon			sition (Name of	Koad,	Rockville	20c. Location - Cit		
Baltimore,	ge 1 a troff H		20a. Method of Disposition 1 ↑ Burial 2 ☐ Cremation 3 ☐	Removal from State	tery, cren	natory or other plac n Nationa	e) 1 De	cember 30.		n, Virginia	
ţ	t. Pag tmen rtant: njury		4 Donation 5 Other (Specific	Zei				2010		- 0	
Bal	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	M01619	Ŕ	phert A.	Pumphre	ey Funeral	Home/Rockville.M	ckville, Inc. aryland 20850	
			23a. Part 1. Enter the disease, or comp	olications that caused the death. Do	not ent	er the mode of dying	g, such as card	diac or respiratory arre	est,	Approximate Interval Between	
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final Notactatic Pacitonese Mesthelione										
	Physician/ Medical		disease or condition resulting in death)	a. Due to (or as a consequence	e of):	201-1	12-0	, 1630.	70		
1	Examiner										
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	uted ad ansit	Examiner	Cause (Disease or linjury that initiated events	C							
	death certificate be executed ne attending physician and ed for use as the burial-transi		resulting in death) Last	Due to (or as a consequence	e oi):						
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68760	tiffica ing pl	Me	IF FEMALE:	23c. If yes, outcome of pregnancy					23d. Date of	of delivery	
9 ×	th cer ttendi	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fetal dead		Ctopic pregnant	СУ		Z3d. Date of Month		
Box	the a	ysic	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	g Unknown	1 50						
P.O.	raw requires that the death certificate be executed as been signed by the attending physician and a should be detached for use as the burial-transit	Completed by Physician/Medical	Part II. Other significant conditions c	ontributing to death but not resultin	g in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use contribu	ite to the cause of death?	
	signe d be	d b						_ 1 🗆 1	/es 2 □ No 3	Probably 4 Unknown	
ğ	been shoul	ete						24a. Was a		re autopsy findings available or to completion of cause of	
ecc	las las	١Ĕ						— autop perfor 1 ☐ Yes	rmed? dea	th? Yes 2 No	
æ	n: The fficate h		25. Was case referred to medical			26. P	lace of Death (Check only one)	ZAINO		
/ita	ysician: is certific director,	To Be	examiner? 1 ☐ Yes 2 ເNo	Hospital:	Outpatie	nt 3 DOA Oth	er: 4 🗆 Nursii	ng Home 5 Resid	lence 6 Other (Specify)	
of/	Attending Physician: If death. ector: After this certific by the funeral director,		27. Manner of Death		o. Time o		y at k?	28d. Describe h	ow injury occurred		
uc	ath. r: Aft	lical	1 Natural 5 Pending 2 Accident Investigatio	1		M 1 🗆	Yes 2 No				
Division of Vital Records,	r Atte	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, st	reet, factory, office		28f. Location (S City or Tow		or Rural Route Number,	
D.	ital or irs aft						11 -11-		(-)	an atatad	
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	O BA - C I Free or	sician: To the best of my knowledg iner: On the basis of examination and	d/or invo	etication in my onini	ion, death occui	rred at the time, date a	nd blace, and due to	the cause(s) and mailler stated	
	the hin 2 the F	Ž	1	se Practioner: To the best of my know	owledge,	death occurred at the			29d. Date signed (
_	5 호 호		29b. Signature and title of certifier	- X	11		0581		12/01	11A	
	•		30. Name and address of person who	completed cause of death (Item 22)	a) (Type		0001		1040		
14			Sam Wanko M.D. 89				la, Mar	yland 2081	4		
<i>ا</i> ا	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature							
	Regist		DEC 0 9 2010	and B. a	bar	1					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010^{ear} 2:02 December Werner A. Uebersax Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Baltimore Blakehurst If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 27 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** 19<u>19</u> 1 X M 2 □ F Days Hours Director 214-12-4073 Yrs. June_ Usual Residence of Decedent 28a-f shov 10b. County be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 😾 No MD Baltimore <u>Towson</u> ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 21204 1055 W. Joppa Road **USA** or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces?
1 X Yes 2 □ No If Yes, Give Black, White, etc. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Specify: 3 Widowed 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic. Aerospace Industry/ Elementary/Seconday (0-12) College (1-4 or 5+) Engineer/Professor Catonsville Comm. Col. 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Uebersax Alvena Buttner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #509; Towson, MD 21204 1055 W. Joppa Road Sarah Uebersax wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2: Cremation 3
Removal from State 4 Donation Other Specify) Hilltop Service Corp. 12/7/2010 Towson, 21. Signature of F 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only on Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Pregnant at time of death 9 Unknown Division of Vital Records. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deal 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural 2 Accident 3 Suicide 5 Pending Investigation after death Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Priyestall. In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Name Practice of The Control (Check or ty che

Registrar

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please Type or Print in B									
			1 - State Of Maryland Registrar	•	tificate of l		, ,	eg. No.	00000			
	Physicia Medic		1. Decedent's Name (First, Middle, Last) CLARENCE WEBS:	Terc			2. Date of Death Month	Day Year	3. Time of Death			
	Examir	er	4a. Facility Name (If not institution, give street and number) Gilchrist Center		4b. City, Town, o	r Location of Deatl	1	4c. County of De	^{ath} imore			
Ī	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) 4 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, June 11	9. B	irthplace (State or Foreign ountry) aryland			
		_	Usual Residence of Decedent				June II	, 1940 M				
	larylan 8a-f sh tified a	ecto	Maryland N/A	own or Loc :Balt	imore				10d. Inside City Limits 1			
	th the N 3a or 2	Funeral Director	10e. Street and Number		10f. Zip Code 2121		1	0g. Citizen of What C	Country?			
	ems 2	une	335 East 31St 11. Marital Status 12. Was Decedent Ever in U.S.	USA 14. Race - Am	erican Indian							
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married Armed Forces? 1X☐ Yes 2 ☐ No 196 1 Yes, Give Year or Dates. 196	4 1	Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto Specify:	o Rican, etc.)	Black, White, etc. Specify: White				
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121	d withi lygiene ther th nt, the	Be Co	12		Manager			Warehous	e			
lanc	be file lental H rked of tic ever	10 B										
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Baltimore,	Page iment o tant: If tant: If jury or		1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro	•	, Maryland							
Balt	permit Depart Import any inj		21. Signature of Funeral Service Licensee Thomas Gregor	2	remation 99 Frede	ss Society rick Road	Of Maryl 1 Baltimo	and, Inc. re, Maryl	and 21228			
	Physician/	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one value on each line. Approximate Interval Between										
9	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Onset and D Due to (or as a consequence of):									
,0	HAN.	Examiner	Sequentially list conditions, if any, leaching to immediate cause. Enter Underlying Cause (Disease or linjury	ee offic								
94	be executed sician and burial-transit	g	that initiated events resulting in death) Last C. Due to (or as a consequent d.	ce of):								
68760	rtificate ing phy e as the	Med	IF FEMALE:									
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. To the Luneral Director. After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the burner of the funeral director, page 2 should be detached for use as the burner and the funeral director.	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal deady 4 Pregnant at time of deady 9 Unknown	eath 3 🗌	Ectopic pregnance Other (specify)	су		23d. Date of de Month	elivery Day Year			
ds, P.O.	requires that the de been signed by the should be detached	ted by PI	Part II. Other significant conditions contributing to death but not resulting to HYPOTHYROLOLS M PULMONARY EMBOLICATION OF THE PULMONARY EMBOLICATION OF TH			ven in Part I.			o the cause of death? Probably 4 Unknown			
Records,	Physician: The law rec r this certificate has be aral director, page 2 shc	Completed by	PULMONARY EMBOLISM 24a. Was an autopsy performed? performed? death? 1 Yes 2 No 1 Yes 2 No									
of Vital	sician: certific irector,	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		Oth	ace of Death (Chec			Uncorre			
on of V	inding Physath. r: After this ie funeral d	Certificate; To										
Division	tal or Atters after de al Directo ed in by the		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,			
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completed filled in by the fu	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge only one) 3 Certifying Nurse Practioner: To the best of my knowledge only one)	nd/or investi	gation, in my opinic eath occurred at the	on, death occurred a e time, date and pla	at the time, date and ce, and due to the c	place, and due to the ause(s) and manner as	cause(s) and manner stated, s stated.			
•	وه م الم		29b. Signature and title of certifier Multiple Allower		29c. License			d. Date signed (Mont				
	V)		30. Name and address of person who completed cause of death (Item 23	a) (Type, Pr	PARTH HA	KIRG BI	(III) MAKO	MD ZI	204			
	Stat Registra	-	31. Date filed Month Day, Years 2010 32. Registrar's Signature	park			COIT					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Phyllis 800 PM WebsTeR 12 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HOSPITal FRANKLIN Square Rosedale 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) 1 □ M 2 □ XF Months Days Hours Min. 216-32-3185 73 Director March5,1937 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinating must be notified at 10d. Inside City Limits Baltimore MD Essex Director 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 318 Ida Avenue 21221 USA Funeral hours after death 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ⋧ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Western Electric 12th f Health and Mental Hy

Tem 27 Is marked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Zang Jr. Beatrice Arkins ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores D. Cushing/sister 318 Ida Avenue Baltimore MD 21221 permit. Pages 1 an Department of Heal Important; If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 12/8/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bilateral PARUMONIO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner C.O.P.D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed Diabetes burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by been sign should be disorder 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1110 director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of Certifie 29c. License number 29d. Date signed (Month, Day, Year) 12-6-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 BaLTO UR Kam Au Y kung FRANKLI Sauare 21237 32. Registrar's Signature 31. Date filed (Mo. State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month WEBB S 2:05AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death Hmore t birthday) Yrs. Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs. 8. Date of Birth M 2 🗆 F Min. Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10g. Citizen of What Country? 21208 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. orces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: Blaci 1 ☐ Yes 2 ☐ No Specify 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname, ၉ 0a. Method of Disposition Place of Disposition (Name of Imetery, crematory or other 20c. Location City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dopation 5 Other (Specify) timore, e of Funeral Service Ligensee Girrene Funeral Services MD 21133 23a. Part 1. Ent / he disease, or co / lications that caused the death. Do not enter the mode of dying, such as cardin, or respiratory arrest shock, or lest it failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami ending physician and use as the burial-transit death certificate be executed Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 2 No 3 □ Probably 4 □ Unknown Completed 1 🗌 Yeş 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? this certificate 2 🗆 No 2. Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) 1 Yes Other: 2 1 No မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending work? Natural injury Division 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check 3 🗌 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2010 00066507 YSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 GREENE 55 0 AND 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signatus State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month Marcel 0328A M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gildnrist Center for Hospice Care TOWSON Baltimore Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, じロロ 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F MD Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho. 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Pikesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7205 Brookcrest 21208 USA Was 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Goodwill Industries 12th grade 'ase Maira 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Ernest Alstor 19a. Informant's Name/Relationship dype, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Denise McCormick Dikesville 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Woodlawn, MD 16/2010 4 Donation 5 Other (Specify) oodlawn Cometen Greene Funeral Srvs 21. Signature of Funeral Service Licensee 22. Name and Address of Facility aughin C, Dandallstown MD 21133 Polet 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ omplications OF disease or condition Medical resulting in death) Due to (or a a consequence of): Examiner Tax 3 1/1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? Completed by due to acure tubular neurous 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 N 2 No 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: ၉ 1 Yes hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural 5 Pending injury 2 Accident 3 Suicide M 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier December 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOW SO N CHARLES 6701 S

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month)

32. Registrar's signature

38699 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2510 Physician/ 251 PM cloves XOI 11 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Min. 1 □ M 2**X** F Months Hours Country Director 74 36 216-34-373 14 Usual Residence of Decedent 28a-f shov 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code ō 10e Street and Number Funeral items 23a U.S.A. 21216 1702 Thomas permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked others any injury or others. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black 3 🗆 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Private Duty 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Melvin Satterfield <u>lannie Lawson</u> 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta Jordan-El-Daughter
20a. Method of Disposition ter 4011 Amy Lane, Randallstown, Md

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or 21133 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12/2/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, On-Site 22. Name and Address of Facility March F/H West 4300 Wabash Av . Signature of Funeral Service Licens 21215 Ave Baltimore, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death imediate Cause (Final Myocardial Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): rdiovascular disease Examiner Hensier Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner as a consequence of): abete To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events been signed by the attending physician and should be detached for use as the burial-tran to (or as a consequence of): resulting in death) Last Physician/Medical 0 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed has certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ Director: After this it in by the funeral dir 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident
Suicide
Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🖂 within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46626 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BURKE-MOREES 2000 Am ARA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 9 2010 Registrar

			Please Ty	pe or Print in Blac	k Indelible Ink. Ensure	All Copies A	re Legible.	•						
			1 - State Registrar AMEND#17perFH,G9	MEND ITEM#1/per	k Indelible Ink, Ensure A. H., G910, 12/9/2010, WS Department of Health and I FH, G910, 12/10/2010, Certificate of Death	Mental Hygie WS Reg.	ne . No 2 0 1 0	38700						
	Physicia Medic		1. Decedent's Name (First, Middle, Last) CHESTER			2. Date of Death Month	Day Year	3. Time of Death						
	Examin		4a Facility Name (if not institution, give stree TOOD SAMAH TALK	t and number)	4b. City, Town, or Location of Death		4c. County of Deat							
	Funeral Director		5. Social Security Number 6. Sex.	7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	1944 9. Bird	thplace (State or Foreign untry)						
	land show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	1			10d. Inside City Limits						
	the Mary or 28a-f e notifie	Direc	10e. Street and Number	41	TIMOre 10f. Zip Code	10g	. Citizen of What Co	1 Yes 2 □ No ountry?						
	ath with	Funeral Director	11 Marital Status 12. V	Was Decedent Ever in U.S.	2/239 13. Was Decedent of Hispanic Origin? (Sp		USA							
9800	urs after dea tural", or ite al Examiner	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White Specify:							
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at t, the Medical Examiner	Completed	15. Decedent's Educati (Specify only highest grade co Elementary/Seconday (0-12)	ompleted) (Decedent's Usual Occupation Give kind of work done during most of work ife, DO NOF-use retired) DIEF ENGINEEY	king 16t	b. Kind of Business I	ate University						
ryland	uld be filed of Mental Hygmarked oth	To Be	17. Father's Name (First, Middle, Last) Leonard Leonara Johnson	den Surname)	,									
₃, Ma	and 2 should Health and Mi em 27 is mar ither traumati		19a. Informant's Name/Relationship (Type, P	Marsha Young Wife 1322 Walthers Avenue Baltimo										
ltimore	permit. Page 1 a Department of H Important: If ite any injury or ott	20a. Method of Disposition 20b. Place of Disposition (Name of perpetery, crematory or other place) 20c. Location - Cit perpetery, crematory or other place) 20c. Location - Cit perpetery, crematory or other place)												
Ba	permit. Departri Imports any inji		21. Signatur of Funeral Ferrice Licensee	MOVE, Ma	. 21212									
-	hysician/ Medical		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call Immediate Cause (Final disease or condition resulting in death)	use on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death						
	Examiner	er	Sequentially list conditions, b. —	Due to (or as a consequence of)	:									
(executed an and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events c	Due to (or as a consequence of)										
	9 F 5		resulting in death) Last	Due to (or as a consequence of)	:									
). Box 687	iaw requires that the death certificate be nas been signed by the attending physicis 2 should be detached for use as the bu	Physician/Medical	in the past 12 months?	f yes, outcome of pregnancy Live Birth 2 Fetal death Pregnant at time of death Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deli Month	ivery Day Year						
s, P.O	gned se d	by	Part II. Other significant conditions contribu	iting to death but not resulting in	the underlying cause given in Part I.			the cause of death?						
cord	law requi	Completed				24a. Was an autopsy	24b. Were aut	topsy findings available completion of cause of						
Vital Records,	ian: Ine	Be Con	25. Was case referred to medical examiner?		26. Place of Death (Checi	performed 1 Yes 2 X	y? death? No 1 ☐ Yes	2 □ No						
of Vit	Prnysical sr this ce eral direc	유	1 Ves 2 □ No Hospii 27. Manner of Death 28	1 Inpatient ER/Outp 8a. Date of injury 28b. Tim	ne of 28c. Injury at	ome 5 Residence		fy)						
Division of	oftenomic death. ctor: Affe y the fun	Certificate:	Natural 5 Pending Accident Investigation Suicide 6 Could not be	(Month, Day, Year) inju	ury work? M 1 ☐ Yes 2 ☐ No			- Constant						
	outal or a ours after eral Direct	sal Cer	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
the Hear	the Function 24 ho the Function 24 ho the Function 24 ho the Function 24 ho the Function 34 hours and 34 hour	Med	(Check 2 Medical Examiner: O only one) 3 Certifying Nurse Pra	n the basis of examination and/or in	nvestigation, in my opinion, death occurred at dge, death occurred at the time, date and place	t the time, date and pla	ace, and due to the c	ause(s) and manner stated.						
	o o o		29b. Signature and title of certifier Wave.	2.5	29 License number 0 0 0 (823 0	294	Pate signed (Month,	, Day, Year) N 9, 2010						
	8		30. Name and address of person who comple	eted cause of death (Item 23a) (Types of the DHARAN	DOO (8230) pe, Print ood Sama	intan H	ospital	MD21239						
	State	C	31. Date filed (Month, Day, Year)	32. Registrar's Signature				1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ϊ́Ò, 2010 8:05p M November Louis E. H. Allen Medical b. City, Town, or Location of Death Silver Spring 4a. Facility Name (if not institution, give street and number) lc. County of Death
Montgomery Examiner 102 Sheffield Street 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) ec. 5,1928 81 Days Indiana 1 🕱 M 2 🗆 F 307-24-8709 Director Dec. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Kes 2 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country?

United States 10e Street and Number 20910 Completed by Funeral 102 Sheffield Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White stcan 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 □ Divorced American Year or Dates 1967 – 1970 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ntal Hygiene. ed other than " event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Clinical Pathologist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be filed the and Mental H 27 is marked of traumatic ever P Johanna Peyton permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. John Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 555 Thayer Avenue, #109, Silver Spring, MD 20910 Joanna Duell/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 12/13/2010 Arlington, VA Arlington National McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7400 Georgia Avenue, N.W. Wash., D.C. 20012 23a. Per 1. Enter the disease, or complications that caused the chath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 6 years disease or condition resulting in death) Stage III Chronic Kidney Disease Medical Due to (or as a consequence of) [•]Examiner 5 years Coronary Artery Disease Sequentially list conditions, if at y, reading to incrediate cause. Enter Underlying Examine Due to for as a consequence of as the burial-tras. 20 years Hypertension Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Congestive Heart Failure 5 years attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 L Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Day 5 Other (specify) Pregnant at time of death detached. the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signed page 2 should be det þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No nours after death.

neral Director: After this certifical filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 **X** No 4 ☐ Nursing Home 5 Kesidence 6 ☐ Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical ectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the the 29b. Signature and title of certific 2 November 18, 2010 VA0101034873 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year,

Margretta Diemer, M.D. WRAMC, Building 2, Washington, D.C. 20307-5001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eric Brandon Baugher November 2010 12:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10105 Gladstone Street Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) Jan 17, 1976 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 🙀 M 2 🗆 F Months Hours Min. Director 213-88-4225 Maryland ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Numbe 10g. Citizen of What Country? Funeral 10105 Gladstone Street 20902 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner 14. Race - American Indian Armed Forces 0 1 ☐ Never Married 2 🔀 Married Black, White, etc. þ 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural". 3 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Landscape Architect Landscaping injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o 2 Ella Glynn Baugher Mae Mustard t and 2 should by the Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lauren Brandes/ wife 10105 Gladstone Street Silver Spring, MD 20902 Baltimore, item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/29/2010 Woodbine, Maryland 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M any M00957 MD21029 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Sarcoma Metastatic disease or condition norths Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? Yes 2 No death? certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 3 Suicide 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) D68872 23 November 2010 and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar W. Mitch

Rm 1363

N. Brandway

Registrar's Signature

401

Baltimore, MD

31931

Tohns Hopkins Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Of IVIA	ryland / Dep <i>Ce</i>	rtificate of			leg. No?	38703				
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dear Month	Day Yea					
1	/Medic		EVELYN LORETTA BOUMA		Ab City Town o	r I cention of Dooth	Nov	15 2010 4c. County of De					
	Examin	er	4a. Facility Name (If not institution, give street and number) Genesis HealthCare – T	ho Dines		r Location of Death aston		Talk					
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)				
	Director		100 20 7021	00 Yrs.	Months Days	Hours Min.	06/19/1	910	IL				
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits				
	Maryla f sho	tor	MD TALBOT	EAST					1 X Yes 2 ☐ No				
	r 28a	irec	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What	Country?				
	th with	Funeral Director	700 PORT STREET		2160	1	1	UNITED STA	ATES				
	r dea	nnei	11. Marital Status 12. Was Decedent 1 Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	Hispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.				
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates:	10	1 □Yes 2 X No	Specify:		Specify:	WHITE				
9-9	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or items 23a or 28a-f show ent, ite Medical Exactions in a must be notified.		15. Decedent's Education	16a. Deco	edent's Usual Occup	pation		16b. Kind of Busine	ss/Industry				
na 215	thin 73 ne. I an "n Me J	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	+) \lambda \life.	DO NOT use retired	during most of worki d)	ng	OUDI HOME					
Bouma nd 2121	filed wi Hygien sther th			HOME	MAKER	18. Mother's Name	/First Middle	OWN HOME					
Be	nta! He fill	Be	17. Father's Name (First, Middle, Last) MARCUS BERTSCH			NELLIE I		waiden Surname)					
y y	should be and Mental s marked o umatic ev	오	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ina Address (Street			er, City or Town, Stat	e, Zip Code)				
e da	and 2 s ealth ar n 27 is ner trau		SUSAN B. DEERIN/DAUGHTER	1	•	RRIS ST.,							
Ev.	es 1 ar of Hea ritem		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State	20b. Place of Disp	osition (Name of matory or other pla		ate	20c. Location - City	or Town, State				
Ë	Pages ment of ant: If its ury or o		4 ☐ Donation 5 ☐ Other (Specify)	CHESAPEA CENT	matory or other place KE CREMAT ER	11/17	/2010	STEVENSVI	LLE, MD				
Evelyn Bouma Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Moulded Evanciant must be notified any once.		21. Sign it of Funey I Service Licenson	m CFS	FELLOWS, 200 SOUT	ess of Facility HELFENBE H HARRISO	IN & NE	WNAM FUNE EASTON, M	RAL HOME, PA D 21601				
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	Physician		Immediate Cause (Final disease or condition resulting in death) a. Adult failure to first the figure in the first t										
	/Medical Examiner		resulting in death) Due to (or as	a con equence of):		V. C.			1				
		er	Se uentially list conditions b. Due to or as	a consequence of):					grans				
	uted d ansit	Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to or as	nosdeno	M				wears				
oʻ	ificate be executed g physician and as the burial-transit	Exa	resulting in death) Last Due to (or as	a consequence of):					X				
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Вох	attende for us	cian	in the past 12 months?	2 Fetal death 3	☐ Ectopic pregnand	су		23d. Date of Month	Day Year				
P.0.	w requires that the death certifis been signed by the attending should be detached for use as	Physician/M	1 Yes 2 No 4 Pregnant a 9 Unknown										
ر. ت	s that gned t	by Pi	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	obacco use contribut	e to the cause of death?				
ord	equire sen sig ould b	ped k					1 🗆 Y	′es 2 No 3	Probably 4 Unknown				
ec	law r nas be 2 sh	Completed		***			24a. Was autop	sv prior	e autopsy findings available to completion of cause of				
<u>=</u>	sician: The law certificate has rector, page 2 t	S					1 □Yes	rmed? deat 2 2 No 1 □	n? Yes 2□No				
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of	y Phy er this eral d	i.T	27. Manner of Death 28a. Date of Inju	iry 28b. Time	of 28c, Inju			now injury occurred	эреспу)				
ë	ttending death. ctor: Afte y the fun	atio	1 ☑ Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	<i>y, Year)</i> Injury		Yes 2□No							
Division of Vital Records,	ipital or Attending Physician: ours after death. Ieral Director: After this certific filled in by the funeral director,	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, et	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory, office		28f. Location (5 City or Tou	Street and Number o vn, State)	r Rural Route Number,				
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier (Check only one) 29 Medical Examiner: On the basis of and manager standard an	f examination and/or									
	To the Hos within 24 ho To the Fun completely	Medical	one) and manner st 29b. Signature and title of certifier	aleu.	29c. Licen	se number		29d. Date signed (M	lonth, Day, Year)				
	P ≯ P Ō		▶ /M// nn	>	D	769933		11.19	10				
	RS3		30. Name and address of person who completed cause of o	leath (Item 23a) (Type	Print)	LANG	EAS	TON MO	21601				
	Sta Registr			ar's Signature	parker			, ,					

10-08486 Kevin Vincent Bord	Please Type or Print in Black Indelible Ink. Ensure All Copies ey State of Maryland / Department of Health and Mental Hy	giene								
	1- For State Certificate of Death Registrar	Reg. No. 2010 38704								
Physician/ Medical Examiner	Kevin Vincent Bordley	2. Date of Death Month Day November 6, 2010 3. Time of Death 0705 hrs								
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Peninsula Regional Medical Center Salisbury	4c. County of Death Wicomico								
Funeral Director	5. Social Security Number 222-54-5377 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) 6-11-1960 DE								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Henry James Bordley Virgie	White, etc. Specify: Black Ork done of the property of the p								
Baltimore, M permit. Pages 1 and 2 Department of Health. Important: If item 2 injury or other traum	20a. Method of Disposition Comparison of Disposition Comparison of Disposition									
Physician Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	respiratory arrest, shock, or heart Approximate Interval Between Onset and Death								
Box 68760, c death certificate be executed the attending physician and ed for use as the burial - transit hysician/Medical Ex	d. UNPENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown AMENDED 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 5 Other (Specify) 9 Unknown	23d. Date of delivery Month Day Year								
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician burneral director, page 2 should be detached for use as the burnal on: To Be Completed by Physician/Medic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No								
ital Fician: Secrific	25. Was case referred to medical examiner? [Hospital: 4 Jenstiont 2 EP/Outputient 3 DOA Other; Nursing	nly one) Residence 6 Other:								
Division ospital or Attend hours after death. nueral Director: y filled in by the 1 Certificatic	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined Planicide 28a. Date of Injury 28b. Time of Injury 0216 hrs 1 Yes 2 No 28c. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Major Road / Highway 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	28d. Describe how injury occurred Passenger auto fixed object collision 28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 13 and Lorette Road, Princess Anne, MD due to the cause(s) and manner as stated.								
To the H within 24 To the Fi completel	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29b. Signature end tiple of certifier 29c. License number 29d. Date signed (Mon.									
	O.C.M.E.	November 7, 2010								
SI OOME	30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, M	D 21201								
State										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra END#29 apenMD, 11/17/10, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 8:00 aM Evangeline Antoinette Barry 2010 Nov. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 5516 Calvert Street Churchton 9. Birthplace (State or Foreign Country) Georgia If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Davs May 15 1923 Hours 87 Director 257-24-4095 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location at 10a, State 10b. Count with the Maryland Director the Medical Examiner must be notified 1 Yes 2 X No Churchton MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? ь 10e. Street and Number 23a Funeral 20733 5516 Calvert Street death or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. White 1 Never Married 2 Married à 3altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify. If Yes, Give Year or Dates Specify: "natural" 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "r. Education Elementary/Seconday (0-12) College (1-4 or 5+) Administration Secretary other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ruth I. Piver John O. Kemp 19a. Informant's Name/Relationship (Type, Print) - Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Default. Page 1 and 2 sho Department of Health an Important: If item 27 is any injury or other trau 2106 Chapman Rd., Hyattsville, MD 20783 Raymond Warner Barry 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date **Nov** 17 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 201d 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. Spring, MD \$00 University Blvd. W . , Silver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/)e disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examine Due to (or as a consequence of) the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last executed and Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? Stenosis 24a. Was an Spinal autopsy performed 1 🗆 Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ➡he basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37934 11/15/2010 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephanie Trifoglio, MD 7500 Greenway Ctr., Greenbelt, MD 20770

Registrar

DHMH 17 Rev 7/2009

State

Year)

31. Date filed (Month

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nov John 2010 Burns 14 11:10p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randolph Hills Nursing Home Wheaton Montgomery 8. Date of Birth (Month, Day, May 18 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 X M 2 | F Year) 931 Director 341-24-8359 79 May NY Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director M D 1 ☐ Yes 2 X No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11800 Rockinghorse Road 20852 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Serves 2 No 1 Never Married 2 Married <u>6</u> Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: Year or Dates. 1957-72 Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5 + Dentist Dentistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked of ၉ Ned J. Burns Nancy A. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health i Anne M. Burns/Wife Rockinghorse Rd. Rockville. ΜD 20852 Date 23 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of \$ <u>=</u> Important: If it any injury or c Nov. 1 K Burial 2 Cremation 3 Removal from State 2010 Silver Spring, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee F22 Amendadress of Federal Home 500 University Blvd. W., Silver Spring, Mu 23a. Part 1. Enter the disease, or complications that Laused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Senility Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): **G**anst law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician a the burial-Physician/Medical P.O. Box 68760 use as 1 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death s been signed by the s g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hyperthyroidism, Hypercholesterolemia Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No Yes 2 X N 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 **X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D56691 Nov. 17, 2010 Sultana, MD of death (tem 23d) (Type Print) Sultana, MD 12107 Heritage Park Circle, Silver Spring,

Registrar DHMH 17 Rev 7/2009

State

30. Name and address

31. Date filed (Month, Day, Year)

MOA

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3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Z per dr., g910, 12/14/2010dhb Reg. NG. Reg. No Date of Death 11/20/2010 1. Decedent's Name (First, Middle, Last) Month 11/20/1915 **Physician** 2:53A^V Olive Thelma Barney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Hours Kearneysville **Funeral** Months Days 1□ M XXF 95 6/18/1915 233-86-7235 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County ¥es 2 No Director Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21795 USA 44 Village Lane Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: white 1 ☐ Yes XXNo altimore, Maryland 21215-0036 Yes. Give 3 X Widowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 10 domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vadna Ruth Bowers Walter Lee Barron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 210 Sentry Lane Martinsburg, WV 25401 William Barney -son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Martinsburg 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rosedale Cemetery 11/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Home VV 25404 22. Name and Address of Facility Rosedale Funeral 21. Signature of Funeral Service Licensee 917 Cemetery Rd. Martinsburg, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HearT Congestive **Physician** /Medical Due to (or as a consequence of): Examiner Bilaleul Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Wove The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐Live birth 2 ☐ Fetal death Year Month Day in the past 12 months2 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ NO 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 2 No AURRIC STEWOS S 2 40 1 ☐ Yes evere Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 COA 1 Yes 2 No 1 Impatient Certification: To After this 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a To the Funeral C 1 🔍 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mule Desert 40061117

State Registrar

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31. Date filed (Month, Day, Year)

Francisco

Daniels 32. Registrar's Signature

NOV 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Manyland / D - State Amend Items 23aPtI,25,27,28a-	epartment of Health and 1 f per me, g920, 10721 Certificate of Death	Yental Hygiene Reg. No.201	38708						
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month Day Year							
	Medic	al	LINDA ANN BEARD	4b. City, Town, or Location of Death	NOV. 16, 2010							
ر	Examin	er	4a. Facility Name (if not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER	ANNAPOLIS	ANNE AF							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		8. Date of Birth 9. E	Birthplace (State or Foreign Country)						
н	Director		3/1-12-9103 30	rs. World Bays Hours	APRIL 21,1952 W	ASH. D.C.						
	show at	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	or Location		10d. Inside City Limits						
	Aaryla 8a-f s tified	rect	MD. ANNE ARUNDEL	EDGEWATER		1 XYes 2 No						
	a or 2	ΘE	10e. Street and Number	10f. Zip Code	10g. Citizen of What	Country?						
	th with ms 23 must	Funeral Director	208 MARYLAND AVE.	21037 13. Was Decedent of Hispanic Origin? (Sp	U.S.							
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	o Rican, etc.) Black, Wi	Black, White, etc.						
21215-0036	hours natura ical E	lete	15. Decedent's Education 16a. I	Decedent's Usual Occupation	16b. Kind of Busines							
215	e. han "r	3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 DAY CARE PROVIDER 18. Mother's Name (First, Middle, Last) WHITE 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) DAY CARE 18. Mother's Name (First, Middle, Maiden Surname)										
	d with lygien ther tl											
60	be filed ental Hy ked oth ic event	To B	17. Father's Name (First, Middle, Last) EDWARD ROLES		ne (First, Middle, Maiden Surname) MILDRED GULI	FV						
aryl	d 2 should baith and Me 27 is mark			ral Route Number, City or Town, State,								
	id 2 sh saith a n 27 is er tra		RALPH E. ROLES/BROTHER 20	08 MARYLAND AVE., EI	DGEWATER, MD. 2103	37						
ore	le 1 and t of Heal If item or other		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State	Disposition (Name of c, crematory or other place)	Date 20c. Location - City	or Town, State						
ţ	it. Page rtment c rtant: If rjury or			INCOLN CEMETERY 11-2								
MULTINIC (MUNICIPALE) MOUDE 1 3801 CLEVELAND AVE., RIVERDALE, MD. 20												
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. **Dean Clark and Uniform Teaching Conset and Uniform Teachi												
F	nysician/ Medical	66. 6	disease or condition resulting in death) a. Due to (or as a consequence of	ideal infan	cran	1						
	Examiner		Multiple Injur	ies with Complication	ons							
	ans t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.									
	ate be executed physician and the burial-trans to	EX	resulting in death) Last Due to (or as a consequence of):	PPROVED BY MEDICAL EXAMINER							
90	ate be ohysici the bu	edical	d	CERTIFICATION	APROVED O							
687	attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of	delivery						
. Box	r the atten	Physician/M	1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month	Day Year						
P.O.	ires that the dea n signed by the a Id be detached f	by Pt	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?						
ds,	requires been sign should be	ted t			1 ☐ Yes 2 ☐ No 3 ☐	Probably 4 Unknown						
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending it completed filled in by the funeral director, page 2 should be detached for use as	Completed			autopsy prior to death	autopsy findings available to completion of cause of ? Yes 2 \sum No						
Ta I	sian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)							
Š	Physic this or al dire	2	1 Wes 1 Inpatient 2 FEV/Out 27. Manner of Death 28a. Date of injury 28b. Ti		Home 5 Residence 6 Other (Sp							
o uoi	eath. or: After the funer	Certificate:	Ponding (Month, Day, Year) inj	me of jury 28c. Injury at work? 50 p M 1 □ Yes 2 🗷 No	28d Describe how injury occurred of a car collided pickup truck							
Divis	tal or Att is after d al Direct ed in by		4 Homicide determined 28e. Place of Injury - At home, farr building, etc. (Specify) Roadway	m, street, factory, office	28f. Location (Street and Number or City or Town, State) Rt 4. Airy Rd., Davids	Rural Route Number, 24 near Mt. onville,MD						
	To the Hospital or Attending Phy within 24 hours affer death. To the Funeral Director: After thi completed filled in by the funeral	Medical	29a. Certifier (Check only one) Gertifying Physician: To the best of my knowledge, d Description of the basis of examination and/or only one) Gertifying Nurse Practioner: To the best of my knowledge, d	investigation, in my opinion, death occurred a	at the time, date and place, and due to the	ne cause(s) and manner stated.						
	with com		29b. Signature and title of certifier Doubles	29c. License number 714374	29d. Date signed (Mo	ntt Day, Year)						
	4		30. Name and address of person who completed cause of death (Item 23a) (Type 1 App Me	decal Plany/	Imopolis M	D 2149						
	Sta Registr		31. Date fileo (Month, Day, Year) 22. Registrar's Signature	well.	U							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month :30AW Physician/ BROOK 04 EANOR NOVEMBA Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** MONIC omery MILESOH MITHSVORA AKOMA PHALC NASHINGTON 9. Birthplace (State or Foreign 8. Date of Birth If Under 24 Hrs Security Number 7. Age (In yrs. last birthday) If Under 1 Year 1 M 2 D F **Funeral** (Month, Day, Year) 5-2-1933 Days Min. 214-36-3517 **Director** 77 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MarylandPrince George Aquasco 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 16900 Eagle Harbor Rd 20608 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 K Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Andrew Gray Bessie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9902 Dale Dr. Upper Marlboro, MD 20772 Rachel Brooks/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 💆 Burial 2 🗌 Cremation 3 🔲 Removal from State Christ CH.Cem 11/19/10 Aquasco, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 20605 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ BRADYCARDIA 0 Jours disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MEIAPOLIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): STAGE that the death certificate be executed and -trans that initiated events Due to (or as a consequence of): resulting in death) Last burialthe attending physician the dor use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy After this certificate has death? 2 🗆 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 👿 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

2133

State Registrar 29a. Certifier

(Check

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERNICE 1X11126124 A1000 32. gistrar's Signature 31. Date filed (Month, Day, Year)

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TRINSVER MOTRINIHEAW

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

THE KOMAT PHRIC M

HOSPITAL

Contifying Nursa Practionar To the best of my knowledge, death occurred at the time, date or

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:25A M 2010 Edward Bradley November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery 9400 Kendale Road Potomac If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth 7. Age (In vrs. last birthday) Funeral Days Hours Min (Month, Day, Feb 25 1 X M 2 □ F Massachusetts Director 473-30-2675 88 Usual Residence of Decedent show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 🗌 Yes 2 🙀 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20854 United States 9400 Kendale Road rral", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 🙀 Married ρ 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural" White 3 Widowed 4 Divorced Year or Dates.1942-45 Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than ' Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene is marked other th 5+ Ground Water Geologist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 27 is marked or traumatic e Pickering Phillips Bradley Rebecca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Wentworth Bradley/daughter 9400 Kendale Road Potomac, Maryland 20854 Department of Health Important: If item 27 any injury or other to once, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State Final Journey Crematory 11/17/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Si Juliure of Funeral Service Going Home Cremation Service P.O. Box 784 attra Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death page 2 should be detached a Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 1 ☐ Yes 2 ☐ No Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 **X**No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check OsintHying Nurse Prantitioner: To the best of my knowledge, death occur. 29c. License number 29b. Signature and 29d. Date signed (Month, Day, Year) yeur 1 D37142 November 16, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

104

State

istrar's Signature

neur

Suite 100 Rockville, Maryland 20850

Coleman, M.D. 1355 Piccard Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paul Howard Brotemarkle Month Day Year November 20.10 11:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland 10690 Rosebriar Court, Apt 112 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** Days 1 🔀 M 2 🗆 F 84 0472374926 Maryland 219-14-6530 **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location must be notified at Director 1 🗆 Yes 2 🖔 No MD Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 10690 Rosebriar Court, Apt 112 21502 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status any injury or other traumatic event, the Medical Examiner Armed Forces?
1 X Yes 2 No 1944-Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 1964 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Sergeant First Class U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Farris မ Roy Brotemarkle Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 12106 Dandelion Avenue, Cumberland, MD Jeffery H. Brotemarkle / Son 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory 11/30/2010 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. . Signature of Funeral Service Licens 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to edical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 $\stackrel{X}{\boxtimes}$ Residence 6 \square Other (Specify) Hospital: 2 🗹 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) funeral 27. Mann Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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nhs

30. Name and address of person who completed cause Gary L. Wagoner, M.D.

2010

31. Date filed (Month, Day, Year)

death (Item 23a) (Type, Print)

Registrar's Signature

D22181

925 Bishop Walsh Road, Cumberland, MD

November 30, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 21, 2010 Maureen Anne Breitenberg 7:50 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Ol ney Montgomery 8. Date of Birth (Month, Day, Year) Sept. 27, 1949 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 M 2 12 F Hours **Director** 61 IL 351-40-0599 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7751 Hiawatha Lane 20855 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 X Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours innert of Health and Mental Hygiene. Tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institute of Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Senior Economist Standards and Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ronald Francis Breitenberg Anne Marie Kastigar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Marie Hollister/Sister 3312 Ashmore Court, Olney, MD 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, MD Signature of Juneral Service Lig Francisd Oddresofficity Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the attending physician and thed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 9 Unknown detached Division of Vital Records, P.O. ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA this To the Hospital or Auconomic within 24 hours after death.

To the Funeral Director: After this was filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D70998 NOVEMBER, 21, 2010 MONTGOMERY GENERAL HOSPITAL, OLNEY, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DHANIREDDY SUMALATHA 31. Date filed (Month, Day, Year) NOV 23 park State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November ^ከተን, 20 ቸዕ 11:20 AM Physician/ Edith Christensen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Silver Spring Renaissance Gardens 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Feb 25, Year 920 North Dakota 579-03-7665 90 Director Usual Residence of Decedent Mous 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Prince George's Silver Spring 1 Yes 2 No Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20904 United States 3160 Gracefield Road RC-1220 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Department of Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Chemist permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important; If item 27 is marked other any injury or other traumatic event, I Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Esther Christensen Gary Erwin 0. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marthe McGrath/Niece P.O. Box 978 Great Falls, Virginia 22066 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Journey Crematory 11/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland Final 21. Sign were of Funeral Service Lice 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD homos M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure unknown disease or condition Medical resulting in death) **Examiner** unknown Aortic Stenosis Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☒ No Year Month Day 4 Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Mitral Valve Stenosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 🗌 Yes 2 🗆 No Yes 2 XN funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Assisted-Hospital Other: 2 🔀 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ After this Living 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔀 Natural work 5 Pending s after death. 1 🗀 Yes 2 🗌 No Investigation Accident the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

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State Registrar 3160 Gracefield

Exerca.

Silver Spring, Maryland 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

<u> Eileen Gemmell, CRNP</u>

23

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Laron Locke MD.

31. Date filed (Month Day,

Registrar DHMH 17 Rev 1/2001 OCME 2006

State

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

2010

32. Registrar's Signature

THE STANCE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Esther Amelia Larson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, Maryland 20903 20c. Location - City or Town, State Adelphi, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave.. Silver Spring. MD20904 Approximate Interval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 4 Nursing Home 5 Residence 6 X Other (Specify 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 29d. Date stoned (Month. Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13635 Baltimore Avenue, Laurel, Maryland 20707 **ORIGINAL**

3. Time of Death

9. Birthplace (State or Foreign

White

10d. Inside City Limits

1 Yes 2 X No

Minnes ota

U.S.A.

9:20 am

Registrar

State

10+1

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Darryl Anthony Hill, M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Albert Physician/ Ceccone Month Nov. 2010 16 $1:25p^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth *(Month, Day,* **J** เว**ทe** 6 **Funeral** 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Days Hours 578-56-3141 Director 64 1946 ΝΥ Usual Residence of Decedent show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits MD 1 ☐ Yes 28☐ No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6013 Goldsboro Road 20817 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married within 72 hours after ģ Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed withi of Health and Mental Hygien fitem 27 is marked other th Commercial Developer Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ೭ Albert Victor Ceccone, Lena Tontar Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) -Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6108 Sherborn Ln., Albert Christopher Ceccone Springfield, VΑ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery permit. Page 1 a Department of F Important: If ite Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 20 Nov. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Silver Spring, 21. Signature of Funeral Service Licenses A Name and Address of Facility Collins Funeral Home Inc. چ 500 University Blvd. W., Silver Spring,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Brain Stem Hematoma Medical resulting in death) Due to (or as a consequence of) Examiner ν_{ℓ} Intercranial Hemorrhage Sequentially list conditions, Due to for as a conseduence of if any leading to his needlate cause. Enter Underlying Exami requires that the death certificate be executed Cause (Disease or iinjury that initiated events Fall and Due to (or as a consequence of): resulting in death) Last burial-10 physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No detached 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Completed 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy The performed this certificate ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 \square No Other: မ XYes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 11/15/10 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniun ☐ Natural 5 Pending 7:39a 2 X Accident Investigation 1 ☐ Yes 2 😾 No Suicide 6 Could not be

Box 68760 P.0. Records, **Division of Vital** Albert ccore,

al or Attending Physician: The safter death. completed filled in by the funeral director, To the Hospital within 24 hours a To the Funeral D Hospital

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 only one) 29b. Signature and title of certif

determined

4 Homicide

Medical

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month. Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6013 Goldsboro Rd., Bethesda, Maryland 2081

Nov. 16, 2010

Greenbelt,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Willie C. 7525 Greenway Center Dr.,

Blair, MD 31. Date filed (Month, Day,

Registrar's Signa

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

<u>Home</u>

State

Registrar

Am 11	ended #8 /23/10	, n All	1s, per FD, Please Type or Print in Black In egany County State of Manyland / Dep		_	•	
	, _ 0, . 0 ,		For State of Walyland / Dep		lental Hygie	ene 2010	38719
			Registrar 1. Decedent's Name (First, Middle, Last)	tificate of Death	Reg	g. No	00112
×.	Physicia Medic	al	CHARLES MELVIN CROSTEN, SR.		Month	19 10	3. Time of Death 0045 M
	Examin		4a. Facility Name (if not institution, give street and number) Western MD Regional Med. Ctr.	4b. City, Town, or Location of Death Cumberland		4c. County of Death Allega	ny
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 214-32-3749 7. Age (In yrs. last birthday) Vrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You 10/25/-	g. Birth Coun 1-9-3-2- M.	place (State or Foreign try) aryland
	yland -f show ed at	ctor	10a. State 10b. County 10c. City, Town or Lo			1	0d. Inside City Limits 1 ☐ Yes 2 【XNo
	or 28a	Director	MD Allegany Cumber	10f. Zip Code	10	lg. Citizen of What Cour	
	with t	Funeral	11715 Cash Valley Road	21502		U.S.A.	,.
	death item: ner m	Fun	Armed Forces?	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	ted by	Year or Dates.	1 ☐ Yes 2 ☐ No Specify:			ite
15-	72 ho n "nat //edica	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki O NOT use retired)	ng 16	6b. Kind of Business Ind	dustry
212	within giene.		Elementary/Seconday (U-12) College (1-4 or 5+)	Self-employed		Masonry	
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name <i>(First, Middle, Last)</i> Oda W. Crosten	18. Mother's Name Viola	Getson		
Man	2 should Ith and M 27 is ma trauma			ng Address (Street and Number or Rura			502
	1 and 2 s of Health item 27 other tra		20a. Method of Disposition 20b. Place of Dispo	LaVale Street	•	Oc. Location - City or To	
mo				natory or other place) n Meml.Gdns 11/2	24/2010	LaVale,	MD
Baltimore,	permit. Page 1 Department of Important: If i any injury or o once.		21. Signature of Funeral Service Lice see	Name and Address of Facility Upo	hurch Fu Cumberla	neral HOme, nd, MD 215	P.A.
			23a. Part Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or tondition resulting in death)	reme lung 1	15 ASE	2	Onset and Death
-	Examiner		Due to for as a offisequence of:				5.05
		iner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				39,12-
	ath certificate be executed attending physician and for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):				
0	be exe	ल	d				
376(fficate ig physas the	Medi					
Box 68760	th certi ttendin or use	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐			23d. Date of delive	ery Day Year
). Bo	the dear	Physician/Medic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 9 Unknown	Other (specify)		Monu	Day Teal
s, P.O.	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours after death. Funeral Director, After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled in by the funeral director, page 2 should be detached for use as the burial-transitied filled fil	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.		use contribute to th	
ord	w require as been s 2 should	plete			24a. Was an autopsy	24b. Were autor	osy findings available mpletion of cause of
Rec	The law cate has page 2 s	Com			performe		
ita	ysician: The is certificate director, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Impatient 2 FR/Outnetien	26. Place of Death (Check			
of V	g Physer this seral di	e: To	27. Manner of Death 28a. Date of injury 28b. Time of	28c. Injury at	me 5 L Residence 28d. Describe how	ce 6 Other (Specify) injury occurred	
O	eath. or: Aft	fical	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	al or Att s after d il Direct ed in by t	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at	the time, date and	place, and due to the cau	se(s) and manner stated.
_	To the I within 2 To the I comple	2	29b. Signature and title of certified	29c. License number		d. Date signed (Month, L	
	6		MU WANTENWY	1 12218	1 N	ovember	19 2010
	nes		30. Name and address of person who completed ause of death (Item 23a) (Type, F	Ish Road-Cun	borland	MD 2	1505
	Star Registra		31! Date filed (Month, Day, Year) NOV 23 2010 Serve F. Grand				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Aleda May Croft November 20, 2010 05:30 PM M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Allegany Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Months Hours Min. 70 Yrs 212-38-5301 Director May 09, 1940 Usual Residence of Decedent death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Evaning institute to other amy Injury or other traumatic event, the Medical Evaning institute to once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20303 Morgan St. SW 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 __No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Hitchines Nettie Middleton ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Croft, Sr. husband 20303 Morgan St. NW Frostburg MD 21532-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Cumberland Crematory November 21, 2010 Cumberland Maryland 4 Donation 5 Dother (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIAC INFARCTION disease or condition resulting in death) 16 DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical JE FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Year 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ≥ ACUTE STROKE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed MRSA PNEUMONTA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2**X**No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. ours after death.
seral Director: / investigation 1 ☐ Yes 2 🗆 No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time. The and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical npletely (Check only date and place, and due to the cause (s) the within To the

State Registrar 29b. Signature and title of certifier

WILLIAM LAMM M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

D0025406

1250 WILLOWBROOK ROAD CUMBERLAND,

29d. Date signed (Month, Day, Year)

NOVEMBER 21.

MD 21502

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month November 2010 Julia Maria Click 1800 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Health Nursing& Rehab Cente Cumberland Allegany 5. Social Security Number g. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 🗆 M 2 ី F Days Min 90 0172871920 Maryland Director 216-22-5083 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at MD 1 X Yes 2 No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 426 Furnace Street or items 23a 21502 USA 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. <u>^</u> 1 X Never Married 2 Married 72 hours after ould be filed within 72 hours aftend Mental Hygiene.

marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Elick Click Marv Elizabeth Carter any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 Furnace Street, Cumberland, MD Carl F. Miller, Jr./ Son-in-law 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Patrick's Cem. 20c. Location - City or Town, State permit. Page 1 and Department of I 1 X Burial 2 Cremation 3 Removal from State 11/29/2010 Mt. Savage, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Adams Family Funeral Home. 22. Name and Address of Facility 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ CORDYARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical nding physi 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ည 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work thin 24 hours after death.

the Funeral Director: After mipleted filled in by the fun 1 Yes 2 Accident
3 Suicide
4 Homicide 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

nos

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Robustiano J. Barrera, M.D.,

31. Date filed (Month, Day, Year,

NOV 29 2010

dies

148 65

200 Glenn Street, Cumberland, MD

2010

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov 16, 2010 Year 7:42 PM Clark Emma Lee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany 714 Sylvan Avenue Cumberland 5. Social Security Number 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 1 □ M 2 □ **F** Min. Hours Jan 1. Director 218-16-3970 87 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD Allegany Cumberland 28a-1 1 XYes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. Fant: If item 27 is marked other than "natural", or items 23siury or other traumatic event, the Medical Examiner must I 714 Sylvan Avenue 21502 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give 3 Widowed 4 Divorced Specify: Completed white Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hotel Clerk Ft. Cumberland Hotel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ralph Edward Clark Idella (Shinholtz) Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 High Lane Cumberland MD 21502 James Clark **Brother** permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Fernation 3 Removal from State Scarpelli Funeral Home, P.A. 11/18/2010 MD 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown 21. Signature of Funeral Service Licenses 22. Name and Address of Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Energy the rise ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cardiomyopathy Sequentially list conditions, it is a list to make a cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed burial-transit Rheumatic heart failure Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Chronic renal failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Hypothyroidism Physician: The 2 🗆 No Yes 2 N 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ne Hospital or Attending Pl n 24 hours after death. e Funeral Director: After th 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my only on the cause of the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the basis of examination and/or investigation, in my only only on the cause of the cause(s) and manner stated. (Check To the I within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0915 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 W. THIRD SNOWM.D CUMBERLAND.

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

NOV 22 2010

68760

Box (

P.O.

Records.

Division of Vital

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Henry Cross, Jr. November 19, 2010 1:55 \mathbf{P}^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Sep. 25, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. 026-12-2789 **Director** Sep. 1925 85 Massachusetts Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Montgomery Village Maryland| Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 20886 20153 Darlington Drive United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. World þ 1 Never Married 2 X Married 5-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced War II Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Professor of Parasitology University Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helena Barnes John Henry Cross TOTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn S. Cross (Spouse) 20153 Darlington Dr., Montgomery Village, MD 20886 Date 24, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State All Souls Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Germantown, MD Signature of Funeral 22. Name and Address of Facility DeVol Funeral Home, M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 Part I vertee the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ 520515 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pheumonia Sequentially list conditions, if a y, leading to in modal cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Late to (a as a consequence of) the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown Yes 2 No 1 ☐ Yes 2 ☐ Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed after death. Director: After this certificate 2 XNo 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 은 the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28a. Date of injury (Month, Day, Year) Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) upleted filled in by determined 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complet 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mane MA DO057124 11/2/110 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Molecular Drive, Suite 206, Rodeville, Maryland 20850 Bao, MD Iruona 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 23 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death VIS Month Day Physician/ 6:15 AM urham ovember 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timor lizabeth Vursing il enter N/A7. Age In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 6. Sex g. Birthplace (State or Foreign Funeral 1 □ M 2 🖾 Months Days Hours Min Country) Jan 8 Day, 1928 212-22-3341 82 PA Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No MD Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3320 Benson Ave 21227 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes Y No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🔀 No Specify. Specify: White ₩Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clarence Bainbridge Gertrude Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Durham 4219 Greys Run Cir. Belcamp, MD 21017 son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 11/26/2010 Dak Lawn Cemeterv Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facilitarry H. Witzke's Family FH, Inc. of Funeral Service Light 4112 Old Columbia Pike Ellicott City, 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death un s Physician/ cins disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Euneral Director. After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the burlat-transit ension Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical mon Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Month Day 4 ☐ Pregnant at time of death g ☐ Unknown 1 ☐ Yes 2 ☐ Unknown Part **U_Other signific**ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F 29b. Signature and title of certifier 29c. License number 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B-onsun Baltimore Avenue MD 3320 and 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John М. Month Dver рМ Nov. 14 2010 7:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 ★ M 2 □ F Days Hours Min. Director 8 3 Yrs. 577-34-5069 June NY ~1927 Usual Residence of Decedent or 28a-f show 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Montgomery Derwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6108 Granby Road 20855 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White than "natural", 3 ☐ Widowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) id Mental Hygiene. marked other tha Administrative Law Judge Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ John W. Dyer Rose Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is . Page 1 and 2 st ment of Health a John A. Dyer/Son 7192 Silverhorn Drive, Evergreen, CO 80439 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery 20c. Location - City or Town, State 5 1 \Burial 2 Cremation 3 Removal from State 23 Nov. injury 4 ☐ Donation 5 ☐ Other (Specify) 2010 Alexandria, 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home 500 University Blvd. W., Silver Spring, MD Part 1. Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Asphyxiation Medical resulting in death) Due to (or as a consequence of): Examiner Obstruction of Airway from Food Sequentially list conditions Examine Due to (or as a nonsequence of, cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical O death certificate be 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death ☐ Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Completed 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Was a... autopsy performed? has certificate 1 Tes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 X Yes 2 🗆 No this 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 hours after death.

uneral Director: After this
ed filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural work? 1 ☐ Yes 2 😿 No 5 Pending injury Accident 11/14/10 6:16 meat stuck in airway Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5441 Wisconsin Avenue, Chevy Chase, MD 20815 Clyde's Restaurant Owithin 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

29b. Signature and title of certifier

Philip 31. Date filed (Month, Day, Year, NOV 17

Philip Strauss,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

29c. License number

8600 Old Georgetown Road, Bethesda,

D04394

29d. Date signed (Month. Dav. Year)

2010

Nov. 14,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 1 Live Birth 2 Fetal death 5 Other (specify) Month Day Year 1 Yes 2 No 3 Probably 4 & Unknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 & Unknown 1 Yes 2 No 3 Probably 4 & Unknown 1 Yes 2 No 3 Probably 4 & Unknown 1 Yes 2 No 3 Probably 4 & Unknown 1 Yes 2 No 3 Probably 4 & Unknown 1 Yes 2 No 3 Probably 4 & Unknown 1 Yes 2 No 3 Probably 4 & Unknown 1 Yes 2 No 3 Probably 4 & Unknown 1 Yes 2 No 3 Probably 4 & Unknown 1 Yes 2 No 3 Probably 4 & Unknown 1 Yes 2 No 3		d sit	m Š	cause. Enter Underlying	Date to for as a	consequence of,:						
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpalue.	0/0	ificate ig phy as the	Med	IF FEMALE.							\perp	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpalue.	Ď ×	h cert tendir r use	an/l	23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy	Ectopic pregnancy	,		23d. Date	e of deliver	ry
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpalue.	2	peen shoul	lete									
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpalue.	<u> </u>	an: Th tificat tor, pa			1		26 Pla	ce of Death (Ch	1 🗆 Yes		☐ Yes 2	2 □ No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpalue.	<u> </u>	nysici nis cer direc			Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatient	Otho			lence 6 X Other	(Specify)	Group Home
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpalue.	5	ng Pł		arc	28a. Date of injury	28b. Time of	28c. Injury	at				orcoap Home
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpalue.	5	tendi leath tor: A the fu	<u>ĕ</u>	2 Accident Investiga	ation							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpalue.	2	or At after of Direct in by	e		28e. Place of Injury	y - At home, farm, stree <i>(Specify)</i>	t, factory, office				or Rural F	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpalue.	נ נ	spital nours neral		29a. Certifier 1 X Certifying F	Physician: To the best of m	ıy knowledge, death as	Cured at the time	data and place	and due to the	100(0) 5 = 1 =		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpalue.	:	n 24 h	Med	(Check Z L Medical Ex	aminer: On the basis of exa	mination and/or investic	ation in my opinion	i death occurred	at the time date a	nd place and due:	to the enue	n/a) and manner at at all
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Skpanne.	1	Vithi To th		29b. Signature and title of certifier		, monougo, de						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Gupta, M.D., 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 State 31. Date filled (Month, Day, Year) 32. Registrar's Signature.		12		1 2m	gra			D32332		Nove	mber	8, 2010
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature.		ī										
Registrar NOV 1 8 2010		Ctot	2	Suresh Gupta, M	.v., 9801 Ge	orgia Aven	ue, #220,	, Silve	r Spring,	Maryla	<u>ıd 20</u>	902
					O Assertant	The Alexander						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14 Day 201 0 Margaret DeGiorgio NOV. 5:05рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min. 1 M 2 XF **Director** 86 578-24-3290 Dec 192 Usual Residence of Decedent 7 28a-f shov 10a. State 10b. County 10c. City, Town or Location Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director NOVEMBER 1 Yes 2 No MD Rockville Montgomery 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7010 LeMay Road 20851 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>چ</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify:White DEGIORGIO Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Secretary Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ William Vance Margaret Condry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET Department of Health Important: If item 27 Ellen Lloyd/Daughter 7010 LeMay Rd., Rockville, MD 20851 20b. Place of Disposition (Name of cemetery, crematory or other place Gate of Heaven Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State ò 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. Silver Spring, 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service Licensee Francis Funeral Home Milhigh 500 University Blvd. W., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ PNEUMONIA Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or linjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and transit that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 Physician/Medical Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death Live Birth Z L 1 Com L Pregnant at time of death as been signed by the atteraction 2 should be detached for a in the past 12 months? Month Day Year 9 Unknown 9 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ➡No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Tyes မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending М Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) NOVEMBER 15 2010 and address of derson who completed cause of death (Item 23a) (Type, Print) BRIAN CARPENTER 9901 ROCKVILLE

State

Registrar

31. Date filed (Month, Day, Year)

NOV 18 2010

CENTER DRIVE

MARYLAND 20850

MEDICAL

£2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Henry Davis Harry Jr. 10 2010 Medical Nov 9:05 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 15119 Eastview Drive Upperco Baltimore Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 □**X**M 2 □ F Days Hours Min Country) **Director** 220-26-1630 6/13/1931 Usual Residence of Decedent show 10a. State 10b. County event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f Baltimore MD Upperco 1 Yes 2 X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 15119 Eastview Drive 21155 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ρ ō 1 Never Married 2 Married 1 Yes 2 □ No
If Yes, Give
Year or Dates Korean 72 hours after Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify "natural" 3 Divorced white Completed 6a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Purolator 12 armored car carrier permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henry H. Davis Sr. Florence Lane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herta Davis, wife 15119 Eastview Drive, Upperco, Md. 21155 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Removal from State 4 Donation 5 Other (Specify) Carroll Cremation 11/11/2010 Hampstead, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 Buda Lemmer Main Street, Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ Kesnizatory arrest disease or condition Medical resulting in death) Due for as a sequence of Examiner OPD Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) and I-transit a Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
2 Furnaral Director: After this certificate has been signed by the attending physician and leted filled in by the furneral directlor; page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): burial been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months? Month 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? performed?

Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕅 No မ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Dea t Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident work?
1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State:

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check

Amy

31. Date filed (Month, Day, Year)

Stantz

only one 29b. Signature and title of certific

MD

2111 Manover Pike

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Hampstead.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0060503

MD

29d. Date signed (Month, Day, Year)

11/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) a M 5:25 30 2010 October 0 Physician/ Rita Bertha Drew Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Rockville Montgomery Hospice-Casey House 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number New York Days Hours 0170471926 **Funeral** 1 🗆 M 2 🔀 F 84 119-16-5459 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland Director 1X Yes 2 No Rockville Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 20852 6121 Montrose Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Force 1 Never Married 2 Married 2 😾 No White þ 1 ☐ Yes 2 🙀 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed 16b Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home <u>Homemaker</u> 8 permit. Page 1 and 2 should be filed wilt Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Minnie Pecolech 2 David Fishman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7310 Winterfield Terrace, Laurel, Maryland 20707 Alan C. Drew, son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 😾 Removal from State 4 Denation 5 Cother (Specify) Norfolk Virginia 11/01/2010 Forest Lawn Cemetery 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike. Rockville. Mary Funeral Service Licensee 21. Signature Maryland 20852 MO1255 Part 1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter t Immediate Cause (Final a Respiratory Failure Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Examine ne attending physician and ed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Month in the past 12 months? Pregnant at time of death 4 ☐ Pregnant : g ☐ Unknown Yes 2 No 1 Yes 24. the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Pulmonary Embolism Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Cerebrovascular Accidient autopsy has 2 🗌 No 1 🗌 Yes Yes 2 X No this certificate Pneumonia 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Facility 25 Was case referred to medical Be funeral director, Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 2 No မ 1 L Yes 28c. Injury at 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: work? 1 🗌 Yes 2 🗌 No 24 hours after death.
Funeral Director: After eted filled in by the funer 5 Pending X Natural Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Accident Accident 6 Could not be 4 - Homicide determined

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

**XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3742

29d. Date signed (Month, Day, Year) November 17, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G.	Coleman	MD	6001	Muncaster	Mil1	Road,	Rockville,	Maryland	20855
IAMILIE	ind addition of Francisco							1	

State Registrar

mpleted filled in by

Medical

29a. Certifier (Check

29b. Signature and title

the Hospital

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within 2

certif

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMEND#23eperMD, 11/24/10, BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GLORIA GWENDOLYN DAVIS 11720/2010 2205 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours Min. 06/08/1945 Months Country) Director 254-80-5814 Usual Residence of Decedent show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 14 Yes 2 No MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12843 Locbury Circle, #F 20874 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Specify: Black Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bus Aide Melvin J. Berman Sch. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Daniel Davis Daisy Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn D. Ward - daughter 2843 Locbury Circle, #F, Germantown, MD 20874 20a. Method of Disposition 20b Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State ery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Gą te of Heaven 12/04/10 Silver Spring, MD 21. Signature I Funeral Service Licen 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or comshock, or heart failure List only o ations that caused the dea Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Immediate Cause (Final Physician/ L'erebrovas cular accident disease or condition resulting in death) acute Medical Due to (or as a consequence of): Examiner respiratory failure Sequentially list conditions it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Pregnant at time of death 5 Other (specify) Day Year 4 ☐ Pregnant : 9 ☐ Unknown 1 Yes 2 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? has autopsy performed' After this certificate Yes 2 🗌 No 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital of within 24 hours a To the Funeral D Medical 29a, Certifier E-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) motor DOO 47 386 NOVEMBER 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical center Drive, Rockville, Maryland John. MD 31. Date filed (Month, Day, Year) 3. Registrar's Signature State

Registrar
DHMH 17 Rev 7/2009

2010

NOVEMBER 20,

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			For State	State of Maryl				and M	ental Hyg	giene	0	38731
			Registrar	4)	Cei	tificate of D	Death		F	Reg. No.	10	00/01
	Physicia	an/	Decedent's Name (First, Middle, Las	Paul Isaiah	nauga aga				Date of Dea Month	Dav	Year	3. Time of Death
	Medic		4a. Facility Name (if not institution, give		vanaceau	4b. City, Town, or			Novemb		2010	9:30a м
1	Examir	ier	622 Smallwo	,		4b. City, lown, or	Rocku)		y of Death Montg	ama hu
П	Funeral		Social Security Number 6. Security Number	7. Age (In y	rs. last birthday)	If Under 1 Year_	If Under 2	4 Hrs.	8. Date of Birth	1		place (State or Foreign
	Director		2/5-30-6236	X M 2 □ F	76 Yrs.	Months Days	Hours	Min.	01/27h, Pay	1934	Coun	Ohio
Б	nt It] _	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ontion					1.	
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he M	or 28	ă	Maryland Monte	gomery		10f. Zip Code	Rockvi	lle		10g. Citizen of	What Coun	
with t	23a 1st be	Funeral Director	622 Smallwo	od Road			20850)		rog. Citizen di	U.S	•
leath	items er m	문	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Vas Decedent of His f Yes, specify Cubar			ify Yes or No-	14. Ra	ce - Americ	
36 after o	, or amin	ğ	1 Never Married 2 X Married	1 Yes 2 No		Yes 2 🗓 No		Puerto R	ican, etc.)		ıck, White, e	
	atural cal Ex	Completed	3 Widowed 4 Divorced	Year or Dates.						Specify		White
273-0036 in 72 hours after	an "na Medic	ם	(Specify only highest gra	de completed)	(Give I	lent's Usual Occupa kind of work done di O NOT use retired)		of working	g	16b. Kind of E	Business Inc	lustry
withir	er the		Elementary/Seconday (0-12)	College (1-4 or 5+) 5+		Act	tor			S	elf E	mployed
	d oth	o Be	17. Father's Name (First, Middle, Last)				18. Mother	's Name ((First, Middle, N			
Yiand Jid be filed	Meni narke	မ		anaceau					Hilo	da Smuk	ler	
Mar 2 shou	h and 7 is n traum		19a. Informant's Name/Relationship (Ty	, ,		g Address (Street a						
and and	Healt tem 2 other		Merry Danaceau - 20a. Method of Disposition		b. Place of Dispo	Smallwood	i Koad	, KO				
1101	ent of nt: If i y or c		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Qonation 5 ☐ Other (Specific	Removal from State	cemetery, cren	natory`or other place				20c. Location	•	
Saltimor sermit. Page 1	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fire ral Servic - Licens	10	xford Co				/2010			Home, Inc.
e a	any any		Transfort	" - M0070	1 11	800 New H	lampsh	nane ino	Ave.	ilvor	Snrin	a. MD 20904
П			23a. Part 1. Enter the disease, or composhock, or hear failure. List only or	lications that caused the d	eath. Do not ente	r the mode of dying	, such as ca	ardiac or I	respiratory arre	st,		Approximate
	ysician/		Immediate Cause (Final disease or condition			r Encepha						Interval Between Onset and Death 2 months
	Medical kaminer		resulting in death)	Due to (or as a cons	equence of):	r theephu	uus					Z INOVICIOS
	(GITIIII)	e	Sequentially list conditions,	b. Asthma	vanished in						_	
pa	asit h	Examiner	it any leading to in reduction cause. Enter Underlying Cause (Disease or iinjury	Divi to (or se a none	aquence oty:							
xecut	n and al-trar	Exa	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):							
o pe e	physician and the burial-transit	dical	L	d								
o / o	as th	ıwı	IF FEMALE:		_							
h cert	attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live Birth 2 F	etal death 3	Ectopic pregnancy	,			23d. Da	ite of delive	1
deat	the at red fo	ysici	1 Yes 2 No	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5	Other (specify)				Mo	onth I	Day Year
at the	ed by detacl		Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying cause give	en in Part I.		23e Did tob	acco use cont	ribute to the	e cause of death?
ires t	signe d be	d by	Chronic Lymphoc	cytic Leukem	ia							ably 4 🛛 Unknown
orda,	shoul	lete						_	24a. Was an			sy findings available
he lav	ate has page 2	Completed							autops: perforn	y ned?	prior to com death?	pletion of cause of
an: T	rtifical tor, p	Be C	25. Was case referred to medical	- 0		26. Plac	ce of Death	(Check o	1 ☐ Yes 2 nly one)	No No	1 Yes 2	2 □ No
VII.	direc	10 E	examiner? 1 ☐ Yes 2 🕱 No	lospital: 1 lnpatient 2	☐ ER/Outpatient	3 DOA Other	: _4 □ Nurs	ing Home	e 5 🗓 Reside	nce 6 🗆 Oth	er (Specify)	
ing P	offer th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a work?	at		d. Describe hov			
ttend	tor: A	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	On Discontinuo Al			′es 2□N	_				
lor A	Direct Direct In by	Cer	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, tarm, stre	et, factory, office		28	f. Location (Str. City or Town,		er or Rural F	Route Number,
spita	within 24 nouts are read. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	29a. Certifier 1 🗓 Certifying Physi	i cian: To the best of my kno	owledge, death or	ccured at the time, of	date and pla	ice, and c	due to the caus	e(s) and mann	er as stated	
he Ho	he Fu	Med	(Check 2 L Medical Examin	er: On the basis of examina Practioner: To the best of	tion and/or investi	gation, in my opinion	. death occu	irred at the	e time date and	I place and du	e to the caus	e(s) and manner stated
Tot	ZOUT COUT		29b. Signature and title of certifier			29c, License r	number		29	d. Date signe	d (Month, Da	ay, Year)
	2		1 Glober V	Y >			037142	2		Nove	ember	17, 2010
			30. Name and address of person who co					,			,	
	State	e	G. Coleman, M.D., 31. Date filed (Month, Day, Year)	32. Registrar's Sig	natère 🍱	Suite 1	00, R	ockv.	ille, M	arylan	d 208	50
	Registra	٠	NOV 19 2014) Alone	A Arm							

10-09137 Charles Edward		Please Type or Print in Black Indelible Ink ner State of Maryland / Department of H 1-For State Certificate of D	Health and Mental Hygiene	ible. 2010 38733
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last) CHARLES EDWARD EBNER	2. Date of Death Month November 2	Day 28, 2010 3. Time of Death 1509 hrs
			City, Town, or Location of Death Rockville	4c. County of Death Montgomery
Funeral Director			Months Days Hours Min. Months Days Hours Min. July 30	(MM/DD/YYYY) 9. Birthplace (State or Foreig Country) Pennsylvania
Skaryland 28a-f show any	or	10a. State 10b. County 10c. City, Town or Location Maryland Montgomery Rockville		10d. Inside City Limits 1 XYes 2 No
vith the Maryl	Director	10e. Street and Number 725 Monroe Street		g. Citizen of What Country? nited States
MD 21215-0036 12 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 127 is marked other than "natural", or items 23a or 28a-f shounatic event, the Medical Examiner must be notified at once.	by Funeral	1 X Never Married 2 Married Armed Forces? If Yes, 1 Yes 2 No	ecedent of Hispanic Origin? (Specify Yes or Nospecify Cuban, Mexican, Puerto Rican, etc.) 2 No specify:	14. Race - American Indian, Black, White, etc. Specify: White
036 ithin 72 hours : ne. r than "natur: Iedical Exami	Completed b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's L	of working life. DO NOT use retired)	16b. Kind of Business/Industry Hote1
21215-0 Ild be filed w Mental Hygie narked other	To Be Cor	17. Father's Name (First, Middle, Last) Gilbert Charles Ebner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Ad	18. Mother's Name (First, Middle, Ma Virginia Loftus ddress (Street and Number or Rural Route Numb	S
and 2 shou tealth and N tem 27 is n traumatic	Ě	Ginger M. Ebner (Sister) 106 Ab	erdeen Road, Rockville	, Maryland 20850
MOFE Pages 1 tent of H int: If it		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition crematory or other Metropolita:	n Crem. November 30, 2010	20c. Location - City or Town, State Alexandria, VA
		Curtis E. Deus MOIIIE 10 E.	^{e and Address of Facility} DeVol Funer ast Deer Park Dr. Gaith	nersburg, MD 20877
Physician /Medical ≟xaminer	:	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	node of dying, such as cardiac or respiratory arrest	t, shock, or heart Approximate Interval Between Onset and Death
:	taminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
xecuted 1 and - transit		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.		
क स्व	ledica	X UNPENDED AMENDED 23a, PII, 27, per ME	g910 12/13/10 TT	
OX 68' eath certifi attending		23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery Month Day Year
O. B trithe d by the	됩	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I. 23e. Did toba	acco use contribute to the cause of death?

Division of Vital Records, P.O. Box 68
To the Hospital or Attending Physician: The law requires that the death certif
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending
completely filled in by the funeral director, page 2 should be detached for use as

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Be Completed

Medical Certification; To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive atheroscleortic cardiovascular disease

cular disease	1 Yes 2 ✓ N	No 3 Probably	4 Unknown
	24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy prior to comple death? 1 Yes	findings available etion of cause of
26. Place of Death (Check or	nly one)		
DOA Other Nursing	Home 5 Residenc	e 6 🗸 Other: Scer	ne
28c. Injury at Work? 2	8d. Describe how injury	occurred	

23e. Did tobacco use contribute to the cause of death?

1 🗸 Yes	2 No	1 Inpatient 2	ER/Outpatient 3	DOA Outel 4 Nursi	ng Home 5 Residence 6 🗸 Other: Scene
27. Manner of Dea	th	28a. Date of Injury	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural	5 Pending	(Month, Day, Year)		1 Yes 2 No	
2 Accident	Investigation				
3 Suicide	6 Could not be	28e. Place of Injury - At h	ome, farm, street, facto	ry, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
4 Homicide	determined	(Specify)			or rown, dialey
29a. Certifier	Certifying Physician	. To the best of my knowled	dge death occurred at the	ne time, date and place, an	d due to the cause(s) and manner as stated

one) 2 Medical Examiner: On the basis of examination and/or investigation, i and manner stated.	in my opinion, death occurred at the time, date a	and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
0 1 1/	O.C.M.E.	November 29, 2010

30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registrar

25. Was case referred to medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Maxine June Epperson 2010 Medical 4:40 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester **Funeral** Social Security Number 6. Sex . Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X**XF Months Days Hours Min. Country Illinois **Director** 320-24-4936 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 X No Worcester Berlin 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a edical Examiner must b Funeral 5 Bayview Ct. 21811 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc þ 1 Never Married Married Yes 1 Yes 2XXXII Specify: 3 Divorced If Yes, Give Specify: White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental I should be Henry Dunlap Helen Britten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dean Epperson/Husband Page 1 and 2 Bayview Ct., Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗌 Burial 2 첩 Cremation 3 🗀 Removal from State cemetery, crematory or other place ō Department of Important: If any injury or State Crem. 11/17/2010 Millsboro, DE 4 Donation 5 Other (Specify) First permit. 21. Signature of Funcral Sovice Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final tastanc Onset and Death Ph sician/ Mei disease or condition resulting in death) MGATHS **Medical** Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of, attending physician and for use as the burial-transit executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No To the Hospital or Attending Physician: The law requires that the death Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes ∠ = 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy yes 2 No 2 No 1 🗌 Yes Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the ful Accident Suicide Investigation 6 Could not be 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, logath occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check MD66678-L 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Health way Drive, Berlin, MD 21811 9733 State Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

16/2016

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MAXIN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03:40A M CHARLES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Year May 27, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ፟፟፟ M 2 □ F Months Days Hours Min. Mary land Director Yrs. 217-05-1837 94 Ť916 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5792 Flag Flower Place 21045 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1

Yes 2

No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 21 No Specify: Specify: 3 Divorced Year or Dates 1942-45 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Sales Insurance/Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Henry Fiege, Sr. Marie Madrgen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra Shirley M. Fiege/wife 5792 Flag Flower Place Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 11/24/2010 Woodbine, Maryland 21. Signature of Funeral Service Licens M00957 Reverly L. Heckrotte, P.A. Clarisville, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final SEPTIC Onset and Death Physician/ disease or condition Medical resulting in death) Examiner EumoniA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No Month g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CAILLRE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an is certificate has director, page 2 s autopsy performed Yes 2 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this hours after death.

neral Director: After this illed in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending work?
1 Yes 2 No Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined e Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day

Baltimore, Maryland 21215-0036

68760

Box

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ 22, 2010 Foley, Jr. 4:15 A M Paul John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 4835 Cordell Avenue #1402 Bethesda If Under 1 Year If Under ial Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Georgia Days Mar 11, 1944 1**X** M 2 □ F Months Hours Min. **Director** 059-34-3481 66 Usual Residence of Decedent or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 XNo NC New Hanover Wilmington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28411 United States 512 Captain Dexter Wynd within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates, 1968–70 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Private Practice Law Attorney Be permit. Page 1 and 2 should be filed very Department of Health and Mental Hygemportant: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Foley, Sr. India Jeanette Hancock John Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Captain Dexter Wynd Wilmington, NC 28411 Carroll Lee Metzger/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 11/29/2010 Woodbine, Maryland 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 Homos 23a. Part \ Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Malionant Neoplasm Pancreas Medical Examiner sician and burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Completed by Physician/Medical ned by tl

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

To Ba Medical Certificate:

thours after death.

uneral Director: Afted filled in by the fur completed

	and the standard of the standa	a					
	resulting in death)	Due to (or as a consequence of):					
	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):					
	resulting in death) Last	Due to (or as a consequence of):					
	IF FEMALE: 23b, Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	opic pregnancy er (specify)			23d. Date of delivery Month Day Year	
	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ving cause given in Part I.	23e Did t	obacco u	se contribute to the cause of death?	
`	, c						
				1 🗆	Yes 2	☐ No 3 ☐ Probably 4 ☐ Unknov	vn
				24a. Was auto perfo 1 Yes	psy ormed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	e
	25. Was case referred to medical		26. Place of Death (Check	k only one)			
	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other:	ome 5 🗆 Besi	dence 6	Other (Specify) 2nd	
	27, Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of injury M	28c. Injury at work?	28d. Describe		NESTREIN	:e
	3 Suicide 6 Could not b 4 Homicide determined		ctory, office	28f. Location (City or Tov	Street and vn, State)	l Number or Rural Route Number,	
	(Check 2 Medical Examonly one) 3 Certifying Nur	sician: To the best of my knowledge, death occur niner: On the basis of examination and/or investigatio se Practioner: To the best of my knowledge, death	n, in my opinion, death occurred a	t the time, date a	and place,	and due to the cause(s) and manner sta	ated.
	29b. Signature and title of certifier		29c. License number		29d. Date	e signed (Month, Day, Year)	

MD 5824

NW #817 Washington, DC 20037-1475

November 23, 2010

State Registrar Bryan J.

31. Date filed (Month

LOX

Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

2440 M.

32. Begistrar's Signature

Arling,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ovembe 20 2010 /Medical Hity Name (If ot institution, gip City, Town, or Location of Death County of Death Examiner If Un If Unde Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Sec Age (In vrs. last birthday **Funeral** Days Hours 1 □ M 2 1 155-28-9639 Yrs 76 Director 12, Dec. 1933 New Jersey Usual Residence of Decedent 10a. State North 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 24 No Director Carolina Surry State Road 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be Is any injury or other traumatic event, the Medical Examiner must be Is 2001 Zephyr Mountain Park Road 28676 Funeral United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 9 Specify: 3₺ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel A. Russell 2 Mary Ellen Batson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danelle DeLoach / Daughter 8 Deerwoods Court Myersville, Maryland 21773 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State November 4 ☐ Donation 5 ☐ Other (Specify) 22, 2010 Stauffer Crematory Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Juneral Service Licenses 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's consequence of Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy
performed?

1 Yes 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3□ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation Natural Injury death. 1 🗌 Yes 2 🗆 No 2 Accident the Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hin 24 hours after the Funeral Direct 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001 Obricht Rock Symurille

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1

31. Date filed (Month, Day, Year)

helb

32. Registrar Signature

F1190

10-08541 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Poepartment of Aedith and Mental Hygiene Mohammad Mehdi Fartash 38737 Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day November 7, 2010 Medical Examiner Mohammad Mehdi Fartash 1925 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Silver Spring Montgomery 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours 216-92-4412 1 X M Country) Iran 2___F 85 12/20/1924 Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland | Montgomery or items 23a or 28a-f shomust be notified at once. Silver Spring 1 X Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified as name. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ᡖ 14508 Homecrest Road, #311 20906 IISA Funeral 11 Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Never Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: White Specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Iranian Embassy, Minister and Council of 21215-0036 Washington, DC 5+Commercial Affairs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aboutaleb Fartash Masamomeh Zahra Abootaleb UNK Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avid Fartash, daughter 11708 River Road, Potomac, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State crematory or other place) Parklawn Memorial 4 Donation 5 Other Specify: /15/2010 Rockville, Maryland grature of Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC Bal MO1255 1170 Rockville Pike, Rockville, Maryland 20852 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line (Madieul veen Onset and a. Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed Due to (or as a consequence of): and - transit sician/Medical certificate has been signed by the attending physician ector, page 2 should be detached for use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Dav past 12 months? 2 Year Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown 9 Unknown P P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 / Inpatient 2 Other 4 this ER/Outpatient 3 Nursing Home 5 Residence 6 Other 1 V Yes ဥ 2 No 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Nov 7, 2010 Division 1 Natural Pedestrian struck by auto while crossing street 0830 hrs 5 Pending 1 Yes 2 V No the To the Funeral Director: 2 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) Bel Pre Road and Connecticut Road , Silver Spring , MD (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 8, 2010 00 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State

Registra

Day, Year

32 Registrar's Signature

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Physici Medical Exam		Misa	el Abdias F		s			Moni Nove	of Death th D ember 1)ay Year 2, 2010	3. Time of Death 2143 hrs
		4a. Facility Name (if not instit Baltimore Washing				4b. City, Town, Glen Burn		of Death		4c. County of i	
Funeral Director		5. Social Security Number 579–17–6113	6. Sex		n yrs. last birthday) 21 Y	If Under 1 Ye Months Da rs.	ays Hours	Min.	e of Birth (9. Birthplace (State or Foreig Country) Vashington, D
any		Usual Residence of Deceden 10a. State 10b. Cour		110	c. City, Town or Loc	ation				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number			Oren B	10f. Zip Code			10g.	Citizen of What	
h the h 3a or	Ē	8 Kuethe Roa	d			21060				U.S.A.	
11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,									merican Indian, Black,		
							Specify: Hi	spānic			
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212 ould be Menta marke ic even	o Be	Julio Cesar] 19a. Informant's Name/Relation			19b. Mailir	ng Address (Stre	Mari et and Num	a Neris	Flor	es City or Town	State 7in Code)
MD d 2 sho lth and n 27 is		Julio Flores	(Father)			the Rd.					
ore, ssland of Heal If iten		20a. Method of Disposition 1 X Burial 2 Cremat	tion 3 Removal fro		20b. Place of Dispo crematory or o	sition (Name of co	emetery,	Date		0c. Location - Cit	
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		4 Donation 5 Other	Specify:		Parklawn (11-21-1		Rockvill	e, Maryland
Balt permit. Departu Import injury	ě	21 Signature of Funeral Servi		0518	22.	Name and Addres	s of Facility	W.H. Bac	on Fu	uneral H	lome, Inc.
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/Medical Examiner		failure. List only one cau Immediate Cause (Final disea	ise on each line,								Between Onset and Death
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exe	dical	UNPENDED	AMENDED								
Box 68760, e death certificate be excited the attending physician ed for use as the burial -	sician/Medi	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, or				[] Estable		T	23d. Date of deli	-
ox 687 eath certific attending p	iciai	past 12 months?	4 Pregna	nt at time	of death	etal death 3 ther (Specify)	Ectopic	pregnancy		Month	Day Year
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ecol ne law te has	g E							— [_	autopsy performed	? death	
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Vital Physician: this certif	o١	examiner? 1 ✓ Yes 2 No			2 🗹 ER/Outpatient	3 DOA	Other4	Nursing Home	5 Resi	idence 6 0	ther:
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Division of To the Hospital or Attending Phe within 24 hours after death. To the Funerall Director: After tecompletely filled in by the funeral	Medical C	29a Certifier 1 Certifying	Physician: To the best	examinat	wledge, death occur ion and/or investigat	red at the time, dation, in my opinion	ate and place	e, and due to the	cause(s)	and manner as s	stated.
2	§	29b. Signature and title of certi	and manner sta	ea.		29c. Licens	e number		290	d. Date signed (Month, Day, Year)
-			IM. In		-	O.C.I	M.E.		No	ovember 13,	2010
	ſ	30. Name and address of person				- Chr. i 5 ii		ID 2422			
Ch		Jack Titus MD. De	eputy Chief Medica		iner 111 Per	- and the second	imore, M	עונענענע 21201 			

Registrar

al Exam	an/	Registrar 1. Decedent's Name (First, Middle,Last) Lamar Anthony	Feathers	ton		Reg. I Date of Death Month Da	v Year	3. Time of Death
	mer	4a. Facility Name (if not institution, give street and number)		b. City, Town, or Lo		November 4,	4c. County of Dea	ath
		Prince Georges Hospital Center	I a b tab da A	Cheverly	KIII-d Odile- I	9 Data of Birth /a	Prince Georg	
Funeral Director		213-13-4165 1XM 2 F	s. last birthday)	Months Days	If Under 24Hrs. Hours Min.	,	Fore	Birthplace (State or eign Md.
faryland 28a-f show noy at noce,	tor		City, Town or Location	n 10f. Zip Code		I 10a	Citizen of What Co	10d. Inside City Limits 1 Yes 2 No
the Mar in 28s	Director	7803 Oxman Road		20785			U. S. A.	out it y :
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera Department of Health and Mental Hygiera is a factural?, or items 23a nr 28a-f shu Important: If items 71 is marked other than "natural", or ither traumatic event, the Medical Examiner must be notified at once, injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married Armed Forces? 1 Yes 2 X N	If Ye	Decedent of Hispa s, specify Cuban, M	lexican, Puerto Ri		White, etc.	erican Indian, Black,
urs affe tural",	ρ	Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	s Usual Occupation			Specify: b. Kind of Busines	
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d 2 Silousu s Ith and Men n 27 is mar numatic eve	ToF	19a. Informant's Name/Relationship (Type, Print) Apryl N. Featherston (Mother	780:	Address (Street a 3 Oxman R	oad L	andover	, Marylan	nd 20785
ment of Heatant: If ite		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	b. Place of Disposit crematory or oth (esurrect:	ion Cemet	e ry 11/1		Oc. Location - City Clintor	or Town, State n, Maryland
Depart Impor		21. Signature of Funeral Service Licensee #################################		ame and Address of BACO BAAT TAER	Funera Street,	1 _N Home,	Inc. Washingt	on, D. C. 2
ysician Medical aminer		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Gunshot Wo	ath. Do not enter the				shock, or heart	Approximate Interval Between Onset and Death
<u> </u>		or condition resulting in death) Due to (or as a consequence by	e of):					
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E I I I I I	_	events resulting in death) Last Due to (or as a consequence d						
ysician and burial - tra	edic	UNPENDED AMENDED						
Si.	W/u	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of p 1 Live birth 4 Pregnant at time o	2 Feta	al death 3	Ectopic pregnanc	y 	23d. Date of delive Month	ery Day Year
attending physician and for use as the burial - trai	sici	1 Yes 2 No 9 Unknown 9 Unknown					co use contribute	to the cause of death?
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INSTRUCTOR IN THE CAN REQUIRES THAT THE GREAT CETT. After this certificate has been signed by the attendin timeral director, page 2 should be detached for use as	o Be Completed by	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined.	ER/Outpatient 28b. Time of In, FOUND: 2043 hrs at home, farm, street reet	26.Place of 3 DOA Ott jury 28c. Injury a 1 Yes t, factory, office build	Death (Check onliner4 Nursing I at Work? St 2 V No St ding, etc. 26	1 Yes 2 24a. Was an autopsy performe 1 ✓ Yes 2 y one) Home 5 Res 3d. Describe how Jubject shot 3f. Location (Streor Town, State kmon Road and let to the cause(s	24b. Were prior to death 1 will be sidence 6 Oth injury occurred Matthew Hensel and manner as st	autopsy findings available of completion of cause of 2 Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 3:40 PM Finkelstein 2010 November 16, Marcia 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 907 Allan Road Rockville Montgomery 9. Birthplace (State or Foreign Country) New York Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🛣 F Months Days Hours Min 03/06/1946 088-36-4977 64 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 Allan Road 20850-1423 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 x Married ☐ Yes 2x☐ No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LPN **Medical** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Grossman Lily Schneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheldon Finkelstein, husband Allan Road, Rockville, Maryland 20850-1423 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State Judean Memorial Gdns 11/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Olney, Maryland ^{22, Name and Address of Facility} Edward Sagel Funeral Direction, 1091 Rockville Pike, Rockville, Signature of Funeral Service Licenses MO1163 and 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Ph_sician/ Medical **Examiner**

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Important: If ite
any injury or ot

Physician/

Medical

10a. State

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Funeral

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1 and 2 should be filed within 72 hours after death with the Manyland if Health and Mental Hygiene. If Health and Mental Hygiene item 828 or 288-f sho often trainmatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician and I for use as the burial-transit signed by the aid be detached f has page 2 this certificate Ap the Funeral Director: After this certific completed filled in by the funeral director,

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

2 0	Immediate Cause (Final disease or condition	one cause on each line. Brain Metastases				Interval Between Onset and Death 8 months
ner	resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of): Breast Cancer Due to (or as a consequence of):				8 years
lical Exami	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last					
To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown		topic pregnancy ner (specify)		23d. Date of de Month	elivery Day Year
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To E	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hon	ne 5X Residence	6 ☐ Other (Spec	cify)
Medical Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	111	28c. Injury at work? 1 Yes 2 No	8d. Describe how inju	iry occurred	
al Certi	4 Homicide determined		actory, office 2	28f. Location (Street a City or Town, Stat	nd Number or Ru e)	ıral Route Number,
Medica	(Check 2 Medical Exam	vsician: To the best of my knowledge, death occur niner: On the basis of examination and/or investigations re Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at t	the time, date and place	e, and due to the	cause(s) and manner stated.
_	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Mont	h, Day, Year)
	Find NI	1/4-10	D35996	Nov	ember 17	7, 2010

20906

State

Registrar

Linda M. Burrell, MD, 2730 University Blvd, #900, Wheaton, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Ellen Leona Flanary Medical 2010 10:00p. NOV 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Golden Living Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2/21/1918 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 □xF Months Days Hours Country) Director Yrs 216–22–9969 92 Usual Residence of Decedent 28a-f shov 10b. County must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Carroll Hampstead MD 1 Types 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 1310 N. Main Street 21074 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. ö ģ 1 Never Married 2 Married ☐ Yes 2 XNo Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify: "natural", white Completed 3

Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filk h and Mental I 7 is marked ou ပ Ida Victoria Keith David Lorenzo Helton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 soft Health item 27 Gracie Hill, daughter 2439 Fairmount Rd., Lot 1, Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If ite any injury or of Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Pleasant Cem. 11/19/2010 | Gamber, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility 22. Name and Address of Facility Eline Funeral Home 934 S. Main Street, Hampstead, Md. M00741 emmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and -transit certificate be executed Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?

1 Yes 2 No
9 Unknown that the death Month Day Year 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has to page 2 s autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After iniury 1 XNatural 5 Pending s after death.

I Director: Af
d in by the fur 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aff To the Funeral Di completed filled in Medica Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sign WJL MD nd address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month.

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene For State of Maryland / Separtment of Health State RegistramEND#7perFH, 11/19/10, BMW, McCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 12, 2010 Physician/ Mary Francis Flint Foulger Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 11504 Front Field Lane Potomac
If Under 1 Year I If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 88 Days Min. 1 □ M 2 🛣 F Hours 429-14-0910 87 10000-000 20 Director Yrs Usual Residence of Decedent 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location Director traumatic event, the Me Ical Examiner must be notified MD Montgomery Potomac 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20854 United States 11504 Front Field Lane Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Forces . 01 1 Never Married 2 Married Completed by 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give "natural", 3
Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jesse Brough Flint Margaret Howells 19a. Informant's Name/Relationship (Type, Print)
Sidney W. Foulger/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zio Code 11504 Front Field Lane, Potomac, MD 20854 Department of Health Important: If item 27 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-20-2010 Parklawn Cemetery Rockville, MD 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications; at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Chronic Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hypertension, Atrial Fibrillation, Scoliosis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🖾 No page Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 2 X No Hospital: Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 11/15/2010 29c. License number Osph A Ball MD D53317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph A. Ball MD 16220 Frederick Rd. #213 Gaithersburg, MD 20877

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Рм

7:17

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Years

Years

Day

2 🗌 No

1 Ves

1 X Yes 2 ☐ No

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Black White, etc.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

1 9 2010

Please Type or Print in Black Indelible Ink. Fasure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Evelyn C. Fishman November 6:00 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brighton Gardens of Tuckerman Lane N. Bethesda Montgomery 8. Date of Birth
(Month, Day Year)
Jan. 22 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Maryland Yrs Director 216-16-2921 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be martical once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 A Yes 2 □ No MD Montgomery N. Bethesda 10e. Street and Number 10g. Citizen of What Country? Funeral 5550 Tuckerman Lane 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 ₩ Widowed 4 Divorced Specify: Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Rep. US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Solomon Caplan Hannah Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11400 Strand Drive, Apt. 407, Rockville, Maryland Jocelyn N. Davies/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3X Removal from State cemetery, crematory or other place) King David Mem. Grds. 11/15/2010 Falls Church, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Patanzansky-Goldberg Memorial Chapels. 21. Signature of Funeral Service Licensee Migheenhit NWS97 1170 Rockville PIke, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or imjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year Yes 2 No detached 9 Unknown 9 Unknown Records, P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? certificate Yes 2 😾 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: မ 1 Tyes 2 🔽 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury death. 1 Yes 2 No after death Director: / Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Hospital 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D37891

A. Rajvanshi, MD 121 Congressional Lane #403, Rockville, Maryland 20852

November 14, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 17, 2010 9:30P. M MILTON B. FELDMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Renaissance Gardens at Riderwood Village Silver Spring Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Hours 90 Jannt 28², 1**9**20 Newmanyork 131-03-2762 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. if item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Silver Spring Maryland Montgomery 1 Yes 2 No 10f. Zip Code 20904 10e. Street and Number Citizen of What Country? United States 3112 Gracefield Road, #407 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces? 1 X Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Year or Dates. WWII White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Store Manager Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tillie Greenside |Isaac Feldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2255 N.E. 9th Avenue Wilton Manors, Florida 33305 Jay H. Feldman -son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) 11/21/2010 Cedar Park Cemeterv Emerson, New Jersey 4 Donation 5 Other (Specify) Bonald V: Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure Physician/ disease or condition Medical resulting in death) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus, Type II 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 2X No __ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2X No Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

29b. Signature and title of certi-

NOV 19 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

10+

Eileen Gemmell, CRNP 3160 Gracefield Road Silver Spring, Maryland 20904

Registrar's Signature

29c, License number

R1586601

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-	State Registrar			Certifica	ate of De	eath		Reg. No.	2011	J 38/	
Dhusisis	*	1. Decedent's Name (First, Middle, L	.ast)					Date of De Month			3. Time of De	
Physicia: /Medica		Ruth Marga	kner				Novemb		5, 2010			
Examine		4a. Facility Name (If not institution, g	ive street and number)		4b. Cit	y, Town, or Lo	cation of Death		4c.	County of Dea	ath	
		20410 Rainbowvi					mery Vil			Montgon		
Funeral Director		252-05-0402	Sex 1 □ M 2 🖾 F	e (In yrs. last bir 101	Yrs. Month		Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sep 6,	rth ay, Year) 1909	9. Bi	irthplace <i>(St</i> ate or F Country) Lnnesota	
land Dw	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location											
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28a	di l	Maryland Montgo	Juera	1,1	ontgome	ip Code	Lage		10g. Citizen of What Country?			
33 0		20410 Rainbowvie	ow Torraco			20886					,	
ms 2	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Dec		anic Origin? (Sp Mexican, Puerto	ecify Yes or No		nited S 14. Race - Am	nerican Indian,	
0,1	ò	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	10			Mexican, Puerto Specify:	Hican, etc.)	i	Black, Whi	_{ite, etc.} Vhite		
natur	leted	15. Decedent's t (Specify only highest g	Decedent's Us	sual Occupation	n ng most of worki	ng	16b. Kir	nd of Business	s/Industry			
al Hygiene. I other than "national yent, it is Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5	·	Homemak					Own	Home	
We de H	Be	17. Father's Name (First, Middle, Las	st)			18.	. Mother's Name	(First, Middle	, Maiden	Surname)		
and of Health and Mental t: If Item 27 is marked of y or other traumatic ever	၉	William Will	:gen				Carrie					
is m raum		19a. Informant's Name/Relationship	(Type. Print)	19b	Mailing Addre	ss (Street and	Number or Rura	al Route Numb	er, City or	r Town, State,	Zip Code) 2088	
m 27 her ti	1	Betty L. Faulkne	er/daughter								lage, MD	
nent of H	1	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 l	Bemoval from State	20b. Place of cemeter	Disposition (No. 17), crematory or	ame of other place)		Date	20c. Lo	cation - City o	r Town, State	
tmen tant: jury		4 □ Donation 5 □ Other (Spec	ify)	Final .	Journey	Cremat	ory 11/	17/201	0 Wc	oodbine	,_Marylar	
Department of important: If i any injury or once.		21. Significate of Funeral Service Lice	Homen	M00957	Going Bever	and Address of Home C	rematic Seckrott	n Serv	ice E	P.O. Bo	x 784 le, MD 21	
		23a. Parti Enter the disease, or cor shock, or heart failure. List only	mplications that caused	the death. Do							Approximate Interval Between	
nysician	W	immediate Cause (Final disease or condition		tive Ca	rdi omuo	nath					Onset and Dea	
Medical		resulting in death)		a consequence		Laury					3 years	
aminer		Consumation the time and state or	Corona	ry Arte	ry Dise	ase					10 years	
= .	a l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a eunsequence a	5f):							
trans	™	Cause (Disease or injury that initiated events resulting in death) Last	c									
cian a		resulting in death) Last	Due to (or as a	a consequence of	of):							
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ding page as		IF FEMALE:	220 If you outcome	of meanings.								
sheen signed by the attending physician and should be detached for use as the burlat-transit lated by Dhysician/Madical Examin	Sicia	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of the line of the l	2 🗌 Fetal death	3 Ectopic 5 Other (pregnancy specify)			2	23d. Date of de Month	elivery Day Yea	
ad by	Z Z	Part II. Other significant conditions	contributing to death bu	it not resulting in	the underlying	cause diven in	Part I	23e Did t	obacco us	se contribute t	to the cause of deat	
sign d be	0	Hypertension			aayg	given in		1			Probably 4 ☐ Unk	
been	ere							-				
or death. ector: After this certificate has been s by the funeral director, page 2 should tiffication: To Re Commisted	Ē.	Hyperlipidemia						24a. Was autor	psy	prior to	utopsy findings ava completion of caus	
ficate r, pag								1 □ Yes	rmed? 2 X No	death? 1 ☐ Ye	s 2□No	
certif rector	ן מ	25. Was case referred to medical examiner?	Hospital:				. Place of Death	(Check only o	one)			
al dir		1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie	nt 2 ER/Ou	<u> </u>		4 Nursing Hor			- ' '	ecify)	
After funer	5	1X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	(Year)		28c. Injury at Work?		28d. Describe I	how injury	occurred /		
the cart	2	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not 8		m. At home for	M		2 🗆 No	206	0			
0 # T :=		4 ☐ Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						City or Tox	vn, State)	number or H	Rural Route Number	
after d Direct In by 1											as stated. le to the cause(s)	
24 hours after death. Funeral Director: After tely filled in by the funeral control of the funeral Certification.	2	and manner stated.										
thin 24 hours after d the Funeral Direct mpletely filled in by 1	200	one)	O C		25d. Date signed (Mon							
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attend completely filled in by the funeral director, page 2 should be detached for us. Medical Certification: To Be Completed by Dhysician	200	one) 29b. Signature and title of certifier	2/		2							
within 24 hours after d To the Funeral Direct completely filled in by 1	Medica	29b. Signature and title of certifier	Bulour	no		BB1814					th, Day, Year) 16, 2010	
within 24 hours after de To the Funeral Direct completely filled in by t	Medica	29b. Signature and title of certifier	Juliour completed cause of de		Type, Print)	BB1814	397		No	vember		

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Event in a to multipled anone.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		For State of Ma	ryland / Depa			lental Hygie	ne		
_	0	Registrar 1. Decedent's Name (First, Middle, Last)	Cei	rtificate of D	eatn 	Reg. 2. Date of Death	No. 2	3. Time of Death	
Physici		Annamae S. Frazier				Month November	Day Year 2010	8:43 A M	
/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I			4c. County of Death		
	,	333 Russell Avenue, Apt. 60)8		ersburg		mery		
uneral irector		335-16-0612 1□ M 2X F	(In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye April 3 1	ea <i>r) C</i> o	hplace (State or Foreign untry) .ahoma	
Mo to		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
a-f sh	tor	Maryland Montgomery	Gaithe	rsburg			1∭XYes 2☐No		
or 28:	Directo	10e. Street and Number		10f. Zip Code		10g.	10g. Citizen of What Country?		
23a		333 Russell Avenue, Apt.608		20877			USA		
Important: If them 27 is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Madical Eventual or other traumatic event, the Madical Eventual or other traumatic event.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☒ N If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cuban 1 □Yes 2 X No	panic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W		
"natural edical Ex		3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupal kind of work done du DO NOT use retired)	tion uring most of worki		o. Kind of Business/		
ther than	Completed	Elementary/Secondary (0-12) College (1-4or 5+ 5-1 17. Father's Name (First, Middle, Last)	+)	Teacher	10 Matharia Nama	(First, Middle, Maid	Educat	ion	
ked o	To Be	Pericles George Savidis			Ethel L		uen Sumame)		
s mar		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street ar			ity or Town, State, 2	Zip Code)	
n 27 l		Thomas L. Frazier/Son	8649	Sedley Cou	rt, Gait	hersburg,	MD 20879	9	
If Iter or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of matory or other place)	ate 200	. Location - City or	Town, State	
rtant; njury		4 □ Donation 5 □ Other (Specify)	Metropolit						
any ii		21. Signature of Funeral Service Licensee . M. Huran M. Millian	MO1202 10	2. Name and Address DE. Deer	Park Dri	ve, Gaith			
sician edical		23a. Part1. Enter the disease, or complications that caused of shock, or heart failure. List only one cause on each line limmediate Cause (Final disease or condition resulting in death) Due to (pr as a	stive he consequence of):	er the mode of dying	such as cardiac c	or respiratory arrest,		Approximate Interval Between Onset and Death One William	
y physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	enuc C. consequence of): nasy a consequence of):	rtery.	rijeza	se	3		
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown 23c. If yes, outcome of the past 12 months? 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year	
signed b	2	Part II. Other significant conditions contributing to death but	t not resulting in the ur	,	4_*		/	the cause of death?	
ate has bee page 2 shou	Completed	Hypethyraidink.	Prens L	arthro	tex.	24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of	
sertific ector,	Be (25. Was case referred to medical examiner?			26. Place of Death	(Check only one)			
After this of funeral din	ion: To	27. Manner of Death 28a. Date of Injun 1 ☐ Natural 5 ☐ Pending (Month, Day,	t 2 ER/Outpatien y 28b. Time of Injury	28c. Injury Work?	at 2	ne 5 Residence 28d. Describe how in	e 6 🗷 Other (Spen	city) Asst Low	
l Director: d in by the	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injur building, etc.	ry - At home, farm, stre (Specify)		es 2 No	28f. Location (Stree City or Town, S	Street and Number or Rural Route Number, wn, State)		
ne Funera	Medical C	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of and manner state	examination and/or inv	n occurred at the time vestigation, in my opi	e, date and place, inion, death occurr	and due to the caus ed at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)	
To th	ž	29b. Signature and title of certifier	1,	29c. License	number	29d.	Date signed (Month	h, Day, Year)	
2		V Robert Prix and	arkers		115	No	nembe	€18,2010	
		30. Name and address of person who completed cause of de IL. ILOB ERT SIRSCHE 31. Date filed (Month, Day, Year) 32. Registrar	ath (Item 23a) (Type, I BACH W	Print) Z	OI RUI	SOUK	G, MS	20877	
Stai Registra		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	led.			,	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-08793 Jacobo Vasquez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 38747

		1- For State Registrar		Certific	ate of	Death		F	Reg. No.	
Physicia		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year								
Medical Exami	ner								r 16, 2010	1137 nrs
)		4a. Facility Name (if not institution Mile Maker 48 @ Inter		•)	44	o. City, Town, or Lo Frederick	ocation of De	ath	4c. County of Frederick	
Funeral Director		5. Social Security Number none	6. Sex 7. As		te of Birth (MM/DD/YYYYY) 9. Birthplace (State or Fore Country) Mexico					
Ą		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Legation					10d. Inside City Limits
Maryland 28a-f show any d at once.	or	D.C. Washington								
with the Maryland ns 23a or 28a-f sho	Director	10e. Street and Number 1111 Massa	chusetts A	Apt venue l	.317 NW	10f. Zip Code 200	05		10g. Citizen of Wha Mexi	•
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	by Funeral		orced If Yes, Give Year or Dates:	? ! 🔀 No	If Yes	Decedent of Hispa s, specify Cuban, I res 2 No	Mexican, Pue Mexi	rto Rican, etc.)	White,	White
7 3 -1	Completed I	15. Decedent's Education (Spec Elementary/Secondary (0-12) 1 2	College (1-4 or		during mos	s Usual Occupation at of working life. D eaning			16b. Kind of Busi	iness/Industry
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Feliciano Va	azquez Nav				Guada	lupe Gr	Maiden Surname) ande Ba	
MD 21 nd 2 should ulth and Me m 27 is ma aumatic ev	٩	19a. Informant's Name/Relations Sixto Tolent:	nip (Type, Print bro- ino Melcho	r/	1111	Massa	chuse			State, Zip Co20005 7 Wash., DC
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental 1 Important: If item 27 is marked injury or other traumatic event,		4 Donatjon 5 Other Sp		cremat	ory or othe	Municip	al 11		b engras	ansingoico Broingoico
Balt permit. Departi Import injury		21. Signature of Funeral Service	nlo		924	1 Colum	ıbia E	Blvd.Si	lver Spi	VICE,P.A. ring,Md20910
Physician		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			mode of dying, su	ich as cardiad	or respiratory arr	est, shock, or hear	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Multiple (2) Gur Due to (or as a cons		S					Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course	b. Due to (or as a cons	equence of);						
d d ansit	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):						
760, icate be executed by physician and the burial - transit	/Medical	UNPENDED	X AMENDED #1a	s noted,	perME	E,G910,12	2/27/20	010.WS		
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown								'
, P.O. B ires that the d signed by the	by Ph	Part II. Other significant conditi	ons contributing to deat	h but not resulting	g in the und	derlying cause give	en in Part I.			ute to the cause of death?
Division of Vital Records, Ital or Attending Physician: The law requires is after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed							24a. Was autop	an 24b. We priormed? dea	ere autopsy findings available or to completion of cause of ath?
Vital Rec	ē Çō	25. Was case referred to medical				26.Place of	Death (Chec	1 Yes	2 No 1	Yes 2 No
Vita hysicia this ce	O B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 ER/Ou	utpatient :	3 DOA Ot	her Nurs	sing Home 5	Residence 6	Other: Scene
on of anding Ph. th. r: After 1	ion: T	27. Manner of Death 1 Natural 5 Pend	28a. Date of Inju FOUND: Day,Y	^{'ear)} FOU			at Work?	28d. Describe I Subject sho	how injury occurred t	i
Divisior al or Attences after death al Director: ed in by the	Certification:	3 Suicide 6 Could	not be		ırm, street,	factory, office build		or Town, S	tate)	or Rural Route Number, City
Di To the Hospital within 24 hours a To the Funeral I	ledical Ce		ysician: To the best of m	y knowledge, dea	th occurred			nd due to the caus	e(s) and manner as	s stated.
3	Mec	29b. Signature and title of certifier	and manner stated.			29c. License n		•	29d. Date signed	(<i>Month, Day</i> , Year) 7, 2010
	f	30. Name and address of person Carol Allan, MD Ass	who completed cause of distant Medical Exar		Penn Sti	reet, Baltimore	e. MD 212	 01		
		31. Date filed (Month, Day Year)	37 Registra	r's Signature	Book	J.	-, 212			
Regist		NOV 227	OCME	# p. 19	ICINIAL			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

uis Gomez		St 1- For State	ate of Maryla		artment o ertificate of		id Mental F		20	10 38748
Physicia	an/	Registrar 1. Decedent's Name (First, Middl				Boath		2. Date of De		3. Time of Death
Medical Exami			Day Year er 14, 2010	0039 nrs						
		4a. Facility Name (if not institutio 1186 Stone Road	n, give street and nu	mber)		4b. City, Town, or Westminste	Location of Deat er	h	4c. County of Carroll	f Death
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea		_	irth (MM/DD/YYYY)	Birthplace (State or Foreign Country)
Director		None	1 M 2 F	23	Yrs	Months Day	s Hours Mi	June	6, 1987	Mexico
any		Usual Residence of Decedent 10a. State 10b. County	-	10c. City	, Town or Locat	ion				10d. Inside City Limits
* .	'n	Maryland Cari	roll				Westmi	nster		1 Yes 2 No
72 hours after death with the Maryland n "natural", or items 23s or 28sa-f show al Examiner must be notified at once.	Director	10e. Street and Number 1414 Black Lock	act Iano	-		10f. Zip Code	21157		10g. Citizen of Wha	-
ith the		14 14 BLdCk LOCK		edent Ever in U	18 113 Wa	Decedent of Hi	spanic Origin? (S	Specify Ves or N	Mexic	American Indian, Black,
leath w	Funeral	1 Never Married 2 Ma					n, Mexican, Puert	o Rican, etc.)	White,	etc.
after c	by F		orced If Yes, Give Year or Dates:		-		specity:	exican	Specify:	white
2 hours	ted	 Decedent's Education (Specific Elementary/Secondary (0-12) 	College (1				tion (Give kind of . DO NOT use re		16b. Kind of Busi	
5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examir	Completed	8	Joinege (,	,		Janitor			Cleani	ng Company
21215-0036 Migh be filed within 7 Mental Hygiene. marked other than re event, the Medica		17. Father's Name (First, Middle, Francisco Mart.	,	\G	•				Maiden Surname) Villchis	
2121 wild be fill Mental H marked c event,	To Be	19a. Informant's Name/Relations					et and Number or	Rural Route Nu	ımber, City or Town,	, State, Zip Code)
MD 21 d 2 should Ith and Me n 27 is ma numatic ev		Sandra Gomez,	wife							, MD 21157
imore, MD 2 Pages 1 and 2 shou ment of Health and I sant: If item 27 is n or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation	3 X Removal fro	m State	crematory or oth		metery,	Date	Almolo	city or Town, State bya de Juarez,
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other tr		4 Donation 5 Other Sp. St. Signature of Funeral Service		Pai		unicipal Name and Address	of Facility			kico
Ba Perm Depa Impo		Turk R	Julyon				17.	lyers-Du Westmi	rboraw fi .nster, M	neral Home 21157
Physician		23a. Fart I. Enter the disease, or milure. List only one cause		used the death						
√Medical ≟xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Head and C							Death
		Sequentially list conditions,	b	consequence	n).					
	ji	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	of):					
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):					
50, te be executed ysician and burial - transit	edical	UNPENDED	dAMENDED							
'60, cate be o	Med	IF FEMALE:	23c. If yes, o	utcome of preg	nancy				23d. Date of d	elivery
Box 6876 e death certificate the attending phy ed for use as the	Physician/M	23b. Was decedent pregnant in th past 12 months?	I I LIVE DI	rth ant at time of de	acth —	tal death 3	Ectopic pregn	ancy	Month	Day Year
Box e death the atte	hysic	1 Yes 2 No 9 Unk	nown 9 Unkno		5 [] Oti	ner (Specify)				
ion of Vital Records, P.O. Box 6876(trending Physician: The law requires that the death certificate teath. tor: After this certificate has been signed by the artending phy the funeral director, page 2 should be detached for use as the b	by P	Part II. Other significant conditi	ons contributing to	death but not r	esulting in the u	inderlying cause (given in Part I.			ute to the cause of death? Probably 4 Unknown
rds, requires been sig	Completed				·		<u> </u>	24a. Was	an 24b. We	ere autopsy findings available
Recor The law r cate has b	힐								ormed? de	or to completion of cause of ath? Yes 2 No
tal Recian: The certificate ector, page	0	25. Was case referred to medical				26.Place	of Death (Check		2 140 1	Yes 2 No
F Vit	To B	examiner? 1 ✓ Yes 2 No		patient 2	ER/Outpatient		Other Nursi			·
Division of Vital Records, tal or Attending Physician: The law requir rs after death. 19 Director: After this certificate has been seled in by the funeral director, page 2 should be a page 3 should be a	<u>ë</u>	27. Manner of Death 1 Natural 5 Pend	28a. Date of FOUND:	Day, Year)	28b. Time of It FOUND:	· · · · · ·	ry at Work? Yes 2 ✔ No		how injury occurred ito involved in a	
ivisior or Attendather death Director:	Certification		tigation Nov 14, 2 28e. Place		0636 hrs ome, farm, stree	et, factory, office b				or Rural Route Number, City
Diversal of the point of the po	Sel	4 Homicide deter		Major Roa	d / Highway)	or Town, S 1186 Stone F	State) Road, Westminste	er, Md.
Divis: To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		(one only	ysician: To the best							
To 1 With To 1	Medical	29b. Signature and title of certifie.	and manner st		-	29c. Licens				(Month, Day, Year)
MIL		In	1 1/			O.C.	M.E.		November 1	4, 2010
- W3	ŀ	30. Name and address of person				- 04 - 4 5 1		4004		
21	ate	Jack Titus MD. Dep 31. Date filed (Month, Day, Year)	uty Chief Medic	al Examine gistrar's Signati		ın Street, Bal	timore, MD 2	1201		
St. Regist		NOV 1 6	2010	aread .	A 600	Mad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ Robert Carl Guinn 9:27 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Western MD Regional Medical Center Allegany Cumberland 7. Age (In yrs. last birthday) 72 yrs. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthy Country) York 1 🛛 M 2 🗆 F Days Min. Hours (Month, Day, Year) 08/04/1938 131-28-8085 Director New Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Marion 0cala 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3601 W. Silver Spring Boulevard 34475 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1

Yes 2 □ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 72 hours after 1956-1 ☐ Yes 2 √ No Specify: Specify: 3 Divorced 4 Divorced White Completed Year or Dates 1964 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Trucking 12 Owner and Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Keplinger Guinn Jessie Runyon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 3276, Ocala, FL 34478 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any injury or other trains Shirley Ann Guinn / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Roberts FH&Crematory 11/24/2010 Ocala, 22. Name and Address of Facility Adams Family Funeral Home, P.A. Signature of Funeral Service Ligensee 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Inter the disealle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ BILATERAL MEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ANOKIC ENCEPHALOPATHY Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury and -transit that the death certificate be executed CARDIAC FIBRILLATION that initiated events Due to (or as a consequence of): resulting in death) Last ng physician ar Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown g Unknown the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Vonknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? Yes 2 🕏 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tyes 2 No ပ 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a, Certifier Questifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed (Month, Day, Year) D0066606 OLAIDE AJA41, M.D 11-20-2010 61 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

32. Registrar's Signature

12501 Willowbrook Rd. Cumberland, MD 21502

		Please T	ype or Print in State of Marylar				-	0	ble.			
	•	1 - For State Registrar			ertificate of L		viorital Try	Reg. No.	0 38750			
Physicia		1. Decedent's Name (First, Middle, Last) Thelma Mae Greene					2. Date of De Month	eath ember 28, 201	3. Time of Death 11:50 PM _M			
Medic Examin		4a. Facility Name (if not institution, give str Frostburg Village Nursin			4b. City, Town, or	r Location of Death Frostburg		4c. County of Alleg	of Death			
Funeral Director		5. Social Security Number 6. Sex 579-32-8016 1 □	7. Age (In yrs. 83		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, R	oril 13, 1927	9. Birthplace (State or Foreign Country)			
r 28a-f show notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Allegan 10e. Street and Number 26 John!	y 1	ty, Town or LaVale	Location 10f. Zip Code			10g. Citizen of W	10d. Inside City Limits 1 ☑ Yes 2 ☐ No			
s 23a c	neral	20 JOINI	S Latte		21502-			U.S.A.	nat Country?			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	b	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	Was Decedent Ever in U. Armed Forces? □ Yes 2 No If Yes, Give Year or Dates.	S. 1	3. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🗷 No	in, Mexican, Puerto			- American Indian, k, White, etc. White			
within 72 ho giene. er than "nal , the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	ocompleted) College (1-4 or 5+)	(Gi life	cedent's Usual Occup ve kind of work done o . DO NOT use retired) omemaker	during most of working		16b. Kind of Bus				
ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name <i>(First, Middle, Last)</i> Levi King				18. Mother's Nam Blanche		, Maiden Surname)				
nd 2 shou salth and n 27 is m er traum:		19a. Informant's Name/Relationship (<i>Typ</i> e Brenda Atkinson	, Print) daughter	19b. M. 191	ailing Address (S <i>tr</i> eet a 00 Cabin Run R	and Number or Rura Load, S.W. Fi	al Route Numberostburg		yland 21532-			
. Page 1 ar tment of He tant: If iter jury or oth		20a. Method of Disposition 1 □ Burial 2 🕅 Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		cemetery, c	sposition (Name of rematory or other place perland Cremato	:e) !	Date nber 02, 201		City or Town, State and Maryland			
permit Depart Impor any in		21. Signature of uneral Service Licensee	_		22. Name and Address Durst Fund	ss of Facility eral Home, 5'	7 Frost Av	e., Frostburg	g, MD 21532			
Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) a. Dementing Interval Between Onset and Death Due to (or as a consequence of):										
Examiner	J.	Sequentially list conditions, b.	· ·									
ecuted and I-transit	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c. resulting in death) Last	Due to (or as a conseq	<u> </u>								
ate be exemphysician	edical E	d.										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Anours after death. The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown	c. If yes, outcome of pregna 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death		23d. Date Mon	of delivery th Day Year					
uires that the signed by the detail		Part II. Other significant conditions contri	ributing to death but not res	ven in Part I,			oute to the cause of death?					
sician: The law requires that the de certificate has been signed by the rector, page 2 should be detached	Completed by						24a. Was auto perfo 1 \(\sum \text{Yes}\)	psy pr prmed2 de	ere autopsy findings available ior to completion of cause of eath?			
/sician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	FR/Outpa	Othe	er:		dence 6 🗆 Other	(Specify)			
nding Phy ath. r: After thi e funeral o	Certificate: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time injun	of 28c. Injury	at		now injury occurred				
To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	y)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
ne Hosp n 24 hou ne Funel pleted fil	Medical	(Check 2 L Medical Examine)	an: To the best of my know : On the basis of examinatio Practioner: To the best of m	n and/or inv	estigation, in my opinio	n, death occurred at	the time, date a	and place, and due t	to the cause(s) and manner stated			
		29b. Signature and title of certifier	lha		29c. License	-		29d. Date signed				
3		30. Name and address of person who com	pleted cause of death (Item	n 23a) (Type		0		1	29, 2010			
N & Stat	te	HARLI + Sidhu (31. Date filed (Month, Day, Year) NOV 30 2010	925 /3: Sha 32. Registrar's Signa	ture /	alsh Kd	Cumb	erlan	d, mo	21502			
Registra	ar	NOV 3 U 2010	anew B.	Gara	And the second							

Registrar DHMH 17 Rev 7/2009 1. Decedent's Name (First, Middle, Last)

	Physici /Media	ysician John Paul				Goetz		Novemb	ber ² 9, 2010 3:40 А м			
)	Examir		4a. Facility Name (If not institution, gi Golden Living Ce				r Location of Deat berland	h	4c. County of Death Allegany			
	Funeral Director		218-30-0715	Sex 1 X M 2 □ F 7 8	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1932	9. Birthi Mary	place (State or Foreign ntry) 'Land	
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD A11	egany 10c. Cit	ty, Town or Loc	erland				1	10d. Inside City Limits 1 X Yes 2 No	
	3a or 28a	al Director	10e. Street and Number 95 Summit Aven	ue		10f. Zip Code	21502		10g. Citizen of	What Cour	ntry?	
9003	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Mudical Evan har must be notified at once.	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 No 19 If Yes, Give Year or Dates: 19 If	53- 1	Vas Decedent of H Yes, specify Cuba □Yes 2∏X No	dispanic Origin? (S an, Mexican, Puer Specify:	Decify Yes or No to Rican, etc.)	Spec		etc. White	
1215-	within 72 h ene. than "nati	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give I life. D	lent's Usual Occup kind of work done DO NOT use retired .ce Manag	during most of wo d)	rking	16b. Kind of I	_{Business/In} etail	dustry	
Baltimore, Maryland 21215-0036	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Las William	etz	18. Mother's Nai Kathle		aiden Surname)					
, Mary	is 1 and 2 shou of Health and N item 27 Is ma other trauma		19a. Informant's Name/Relationship Deborah G. Brant			g Address <i>(Street</i> Allendal				n, State, Zip 21502	o Code)	
imore	Pages 1 ment of Ho lant: If iten		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State Cur	nberlan	sition (Name of latory or other place d Cremat	ory 11/2		20c. Location	rland	, MD	
Ball	permit Depart Import any in		21. signature of Funeral Service Lice	dans	4	04 Decat	ur Stree	t, Cumbe	erland,		Home, P.A. 21502	
Section of the second	Physician /Medical Examiner	200	23a. Part1. We rithe disease, ir con shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	nplications that caused the deat one cause on each line. a	selen	er the mode of dyli	ng, such as cardia	c or respiratory a	urest, Lisenso		Approximate Interval Between Onset and Death	
,092	eath certificate be executed attending physician and for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b								
O. Box 68760,	ed ed	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown							23d. Date of delivery Month Day Year		
rds, P.	w requires that the s been signed by the should be detach	ed by Phy								23e. Did tobacco use contribute to the cause of de		
Division of Vital Records,	: The law rec cate has bee , page 2 shot	Completed						24a. Was auto perfo 1 □ Yes		were auto prior to co death? 1 🗆 Yes	opsy findings available impletion of cause of	
VII.	certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		Oth		ath (Check only o				
of	Phys r this ral dii	-T	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2	ER/Outpatient 28b. Time of	1 3 DON	4 LA Nuising I	dome 5 Resi			fy)	
ision	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	1 Natural 5 □ Pending 2 □ Accident investigatio 3 □ Suicide 6 □ Could not b		Injury		yes 2 □ No			ow injury occurred treet and Number or Rural Route Number,		
Ω	spital or / ours after neral Dire		4 Hornicide	28e. Place of Injury - At he building, etc. (Specifical)			me, date and place	City or To	wn, State)			
	o the Hos ithin 24 h	Medical	(Check only 2 Medican Exacone) 29b. Signature and title of certifier	miner: On the basis of examina and manner stated.	ation and/or inv	vestigation, in my o	opinion, death occ	urred at the time,	, date and place 29d. Date sign	e, and due to	o the cause(s)	
	1+)	hy 3	_	D3	16766				9, 2010	
	Mas	6	30. Name and address of person who Vikramaditya P	oonai, M.D.,	924 Set	on Drive	e, Cumber	land, M	D 2150	2		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature face to	1 de						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State Registrar	ate of Marylar		artment <i>tificate</i>				Reg. No	4010	3875 2
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Jane T. Griffin						2. Date of	Death 8/20 ^{Pa}	Year Year	3. Time of Death 3:45A M
	Medic Examin		4a. Facility Name (if not institution, give street a Manor Care Bethesda	nd number)		4b. City, To				4c. County of Death Montgome		h
gi	Funeral Director		5. Social Security Number 6. Sex 129-24-8581	7. Age (In yrs. i	last birthday) Yrs.	If Under 1 Months		If Under 24 Hours	Min. (Month,	Birth Day, Year)	Co	hplace (State or Foreign untry)
	Maryland :8a-f show tified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Montgomer		ty, Town or Lo						-	10d. Inside City Limits 1 Yes 2 No
	th the l 3a or 2 t be no	ral Di	10e. Street and Number			10f. Zip C	ode 0817	7		_	tizen of What Co	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 X Married 1 1	s Decedent Ever in U. ned Forces?. Yes 2 ANo es, Give ar or Dates.			nt of Hisp Cuban,	anic Origir Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Ame Black, White	nican Indian,
21215-0036	ithin 72 hour iene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Seconday (0-12) Co 5+		(Give i	dent's Usual (kind of work o O NOT use re her	done dur	on ring most o	of working	1	ind of Business	
Maryland 2	should be filed wand Mental Hygi rand Mental Hygi ranmatic event,	To Be	17. Father's Name (First, Middle, Last) Norman Nevil Tilley		,		1		's Name (First, Mide net Sarah	dle, Maiden	Surname)	
Man	2 shoul th and I 27 is ma trauma		19a. Informant's Name/Relationship (Type, Prin			-			or Rural Route Nun	-		Code)
Baltimore,	Page 1 and ent of Heal nt: If item 2		Edward G. Griffin/Hu 20a. Method of Disposition 1 X Burial 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	al from State	Place of Dispo	natory or othe	of er place)		Date 12/02/20	20c. Lo	ocation - City or	
Balti	permit. P Departm Importa any inju		21. Signature of Funeral Service Licensee	Par	22	. Name and	Address	of Facility	Joseph Ga	wler'	s Sons,	Inc.
00	Continued the executed attending physician and for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate course for a landlying. Cause (Disease or iinjury that initiated events	n each line.	uence of):					arrest,		Approximate Interval Between Onset and Death
Box 6876	•To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/Med	in the past 12 months?	es, outcome of pregna Live Birth 2 Fet: Pregnant at time of a Unknown	al death 3	Ectopic pre Other (spec				-	23d. Date of del Month	ivery Day Year
ds, P.O.	requires that the de been signed by the should be detached	ed by Pi	Part II. Other significant conditions contributi	ng to death but not res	sulting in the u	nderlying cau	use giver	n in Part I.				the cause of death?
Records,	The law requate has bee page 2 sho	Complet							24a. W at pr 1 🗆 Y	itopsy erformed?	prior to death?	oppsy findings available completion of cause of
of Vital	sician: The Is certificate ha irector, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 You	: 1 Inpatient 2	FR/Outrotion		Other		(Check only one)		Пон (6)	7.1
on of \	ending Physiath. Pr. After this one funeral di	ficate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	Date of injury (Month, Day, Year)	28b. Time of injury		. Injury a work?		28d. Describ			7)
Division	ital or Atte ins after de ral Directo	Medical Certificate:	4 🗆 nomicide — determined	. Place of Injury - At he building, etc. (Specify	<i>(</i>)				City or	Town, State))	al Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completed filled in by the funer	Medic	29a. Certifier (Check only one) 3 Certifying Physician: 7 Medical Examiner: On 3 Certifying Nurse Pract	the basis of examinatio	n and/or invest	igation, in my leath occurred	opinion,	death occu ime, date a	urred at the time, da	te and place the cause(s	, and due to the o and manner as	ause(s) and manner stated stated.
	3		h	Perco V		0		57	124	1	te signed (Month	
			30. Name and address of person who complete Truong Bao, M.D.	10110 Mc	lecul	ar Dr	#2	206; F	Rockvill	Le, M	ID 208	50
	Star Registra		31. Date filed (Month, Day, Year) NOV 23 2010	3. Registrar's Signa	dure .	J. S.						

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Thelma Irene Hite November 18, 2010 9:00 A_M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Golden LivingCenter Care & Rehab Frederick 8. Date of Birth Oct. 27, 1930 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Hours Min. Maryland 214-28-5661 **Director** 80 Usual Residence of Decedent and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Frederick Maryland Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 30 North Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: White 3 XX Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse's Assistant Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk.) 2 Elmer Roderick Nellie 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6838 Redbird Lane, Thurmont, MD 21788 Frances Miller / Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, Nov. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Frederick, Maryland 2010 Resthaven Crematory 4 Donation 5 Other (Specify) permit. 21. Signatur of Uneral Solice Licer 22 Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, or complications that caused shock, or beart failure. List only one cause on each line. or complications that caused the death Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a conseq Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery ⊒ Live Birth 2 ⊔ ⊦eযে। uea। ⊒ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year signed by the at d be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗌 No 1 Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: ပ 1 🗌 Yes 2 **N**o 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours

State Registrar

DHMH 17 Rev 7/2009

within 2

29a. Certifier

(Check

only one 29b. Signature

nd title of certifier

30. Name and address of person w

80

completed cause of death (Item 23a) (Type, Print)

Ensige was

ar's Signature

M 32. Regis

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Mortical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Wanitta Lee HENRY 2:55 PM Novembe Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Sept. 14, 78 Yrs. 180-26-5327 1932 Maryland **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Washington Williamsport 1 🖺 Yes 2 🗌 No 10e. Street and Number 243 Maplehurst Avenue 10f. Zip Code 10g. Citizen of What Country? 21795 Funeral u.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white Completed 3 - Widowed 4 - Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygelen. Important If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) assembly worker 10 truck manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Guy William Householder Irene Marion Catherine Daley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffery A. Henry -son 226 Winding Oak Way, Blythewood, S.C. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ob. Place of Disposition of other place)
Cedar Lawn Memorial
Park November 2010 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Onset and Death Physician/ EREBRAL VASCULAR ACCIDENT Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to or as a consequence of Exam or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and I-trans Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year signed by the a d be detached f 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3. CORONARY ARTERY DISEASE 1.HYPERTENSION Records, 1 Tes 2 No 3 Probably 4 Onknown 2. ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? page 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending s after death.

I Director: Af work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Funer completed fil Defitying Prijection: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 71301 11/21/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

WH-7

DHMH 17 Rev 7/2009

EAST ANTIETAM STREET, HAGERSTOWN, MD

251

PHAM

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend Item 24a per med cert G910 12/21/10 dk

State of Maryland / Department of Health and Mental Hydiene.

		-	For State Registrar		State of Ma	•	epartmen Sertificate				giene Reg. No.	2010	38755
	Physicia	n/	1. Decedent's Nam		Hunt, Jr.					2. Date of Dea		i, 20 ^{Year} 0	3. Time of Death 11:53a M
	Medic Examin		4a. Facility Name (if	f not institution, gi	ve street and number)			Town, or Loca	tion of Death	МОЛЕШЬ	4c.	County of Death	
	Funeral	71	Prince G 5. Social Security N		Community B	ospital In yrs. last birthda		ver1y	Inder 24 Hrs.	8. Date of Birt		Ince Geo	rge's place (State or Foreign
	Funeral Director		578-70-3	802	1 X M 2 □ F	58 Yrs	Months	Days Hou		Sept. 2	28°,19	952 Wash	ington, DC
	land f show d at	tor	Usual Residence of 10a. State	10b. County		10c. City, Town or	Location						10d. Inside City Limits
	e Mary r 28a-1 notifie	Sirec	MD 10e. Street and Nur		George's	Upper 1	far1bor				40 0'4'	zen of What Cou	1 X Yes 2 No
	with th	Funeral Director	9508 Ver		ice		207					ited Sta	•
2036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2 Married	12. Was Decedent Ev Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates.	er in U.S.		ent of Hispanie ify Cuban, Me 2 X No Spe		ecify Yes or No- Rican, etc.)	5		ican rican
Baltimore, Maryland 21215-0036	ithin 72 hou ene. r than "nat the Medica	Completed by	(Spe	15. Decedent's ecify only highest onday (0-12)) (G	cedent's Usua ive kind of wor b. DO NOT use	k done during retired)		ing	16b. Kii Neig	nd of Business In Shborhood Corpora Of Ameri	^{dustry} d Assistance ation lca
and 2	e filed w tal Hygi ed othe l event, t	To Be	17. Father's Name (,	liort	gage of	18. N	Mother's Name	e (First, Middle,	Maiden S		-
aryla	nould by		Leon Fre			19b. N	ailing Address	(Street and No	umber or Rura	l Route Number	r, City or	Town, State, Zip (
Š,	and 2 should be filed Health and Mental Hy em 27 is marked oth ther traumatic event				nt/Daughter					timore,			
imore	Page 1 ament of Bant: If ite		20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation		Removal from State	20b. Place of Di cemetery, Chesape	ake Cre	ther place) matory	11/16	,	Be1	cation - City or To tsville,	MD
Balt	permit. Departn Importa any inju		21. Signature of Fu	neral Service Lice	Keesberr	и						al Servi D.C. 20	ce, Inc. 012
	^o h√sician/	8 1	23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition	rt failure. List only (Final	mplications that caused one cause on each line	The second secon	enter the mode						Approximate Interval Between Onset and Death
3	Medical Examiner		resulting in death)	•		consequence of):	65.765	c –					
2	_ +A	iner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate	b. Due to (or as a	consequence of):	ABU	> <u>-</u>					
NO.	icate be executed g physician and is the burial-transit	ledical Examiner	Cause (Disease or that initiated event resulting in death)	iinjury s	c. Due to (or as a	consequence of):							
094	te be e hysiciar he burit	dical			d				·			-	
Box 68	death certil	≥	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months?	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death	3 ☐ Ectopic p 5 ☐ Other (sp				2	23d. Date of deliv Month	ery Day Year
, P.O.	requires that the de been signed by the should be detached	l by Pł	Part II. Other signif	ficant conditions	contributing to death but	not resulting in the	ne underlying o	cause given in	Part I.				ne cause of death?
ords	w requir s been s s should	Completed								24a. Was a	an	24b. Were auto	psy findings available mpletion of cause of
Rec	s ician: The law s certificate has b lirector, page 2 s									autop perfo 1 🗆 Yes	rmed?	death?	
/ital	rsician s certifi lirector	To Be	25. Was case referrence examiner? 1 Yes 2		Hospital:	t 2 ER/Outpa	utiont 3 🗆 DC		Death (Check		danca 6	Other (Specify	d
Division of Vital Records,	nding Physician: Tth. After this certifica tuneral director, p		27. Manner of Deat	h 5 Pending Investigati	(Month, Day,	28b. Hm	9 OT 28	8c. Injury at work? 1 \(\subseteq \text{Yes} \)]:	28d. Describe h			7
Divisio	l or Atter after dea Director I in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 280 Blood of Injury		street, factory	, office		28f. Location (S City or Tow		Number or Rura	Route Number,
0	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Medical	(Check 2	Medical Exam	ysician: To the best of m miner: On the basis of exa irse Practioner: To the be	mination and/or in	vestigation, in r	ny opinion, dea	ath occurred at	the time, date a	nd place,	and due to the ca	use(s) and manner stated.
#	To th withii To th comp		29b. Signature and	title of certifier	fre		29c.	License numb	ber			e signed (Month,	Day, Year)
	,		30. Name and addr		completed cause of dea	ith (Item 23a) (Typ			1 1		J	1/12/2	010
	Stat	e	31. Date filed (Mont	h, Day, Year)	e, 3001 Hos		ive, Ch	never1y	, MD 2	0785			
	Registra	.e		W 22 %	10 Brins	AA							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certifica	ate of Death		7 g. 0.10	eg. No.	10 30/30
Physicia		1. Decedent's Name (First, Midd		Hanna			Date of Dear Month	Day Year	3. Time of Death
Medical Exami	ner	Ramiro 4a. Facility Name (if not institution	Perez	Herna		or Location of Death	November	4c. County o	0955 hrs
		Bon Secours Hospital			Baltimore	or Essention of Boat		io. Godiny o	Bodan
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birth					Birthplace (State or Foreign Country)
Director		none	1 ☐M 2 ☐ F	28	Yrs. Months Da	ays Hours Min	3/13	/1982	Mexico
Å		Usual Residence of Decedent		L.o. o: T					
ow any		10a. State 10b. County Md		10c. City, Town	ltimore				10d. Inside City Limits 1 Yes 2 No
Aaryland 28a-f show	ctor	10e. Street and Number		Ĺ	10f. Zip Code			og. Citizen of Wha	
death with the Maryland or items 23a or 28a-f sho	Director	426 South Ro	binson Str	eet		224	"	Mexic	
with the 138 see noti		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No	14. Race	- American Indian, Black,
death	Funeral	1 X Never Married 2 M	arried Armed Forces?) X _{No}	If Yes, specify Cuba	an, Mexican, Puerto Mexic		White,	White
er, ge	by F		orced If Yes, Give Year or Dates:			o specify:		Specify:	
hours 'natu		 Decedent's Education (Spe Elementary/Secondary (0-12) 		·	Decedent's Usual Occup during most of working lif			16b, Kind of Bus	iness/Industry
36 nin 72 e. than '	ple	1 2	College (1-4 or s	5+)	Cleanin	g		Clean	ing Company
215-0036 be filed within 72 hours al ntal Hygiene. rked other than "natural ent, the Medical Examin	Completed	17. Father's Name (First, Middle,				18.Mother's Name			
21215-0036 ould be filed within 7 if Mental Hygiene. s marked other than ic event, the Medical ic event, the Medical contents and the medical contents are seent, the Medical contents are seen as see	Be (Adolfo Juan							rnandez
AD 21 2 should h and Me 27 is ma imatic ev	7	19a. Informant's Name/Relations Indalecio Ba	hip (Type, long) — 1 n	-law 19b	Mailing Address (Stree 406 Highla				
ore, MD es 1 and 2 sho of Health and If item 27 is her traumati		20a. Method of Disposition	Tranco Naj		f Disposition (Name of co				
Baltimore, MD 2121 bemit. Pages I and 2 should be fi. Department of Health and Mental I important: If item 27 is marked njury or other traumatic event,		1 X Burial 2 Cremation	Removal from Sta	eremato	ory or other place) On San Ba	rtolo	872010	Začat Me:	lan, Puebla, xico
도요를들님		4 Donation 5 Other So	decity:				THINT		
Balti permit. Departm Imports		Mely D.C-	Il.		9241 Col	umbia bl	.vd.Sil	ver Sp	VICE,P.A. ring,Md20910
Physician		23a. Part I. Enter the disease, or failure. List only one cause		the death. Do not					
ixaminer	1 7	Immediate Cause (Final disease	A to 1 -	cohol in	toxication				Death
boxes &		or condition resulting in death)	Due to (or as a conse	equence of):					
4	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse	aguanas afi:					
uted ud ransit	Ë	events resulting in death) Last	d,						
760, cate be executed physician and the burial - trans	Medica	X UNPENDED	X AMENDED #1a 23a,27	s notate	ed, perME, G91	$\begin{bmatrix} 0,12/16/\\ 0,12/13/1 \end{bmatrix}$	2010, WS		
760, icate be ex physician the burial	_	IF FEMALE:	23c. If yes, outcom	ne of pregnancy	per HL gyr	U 12/13/1	.0 11	23d. Date of d	elivery
ox 68° eath certiff	ian	23b. Was decedent pregnant in th past 12 months?	- Elvo birai	time of death 5	Fetal death 3	Ectopic pregna	ncy	Month	Day Year
Box 68 e death certif the attending ed for use as	Physician	1 Yes 2 No 9 Unk	9 Unknown	5	Other (Specify)			Î	ľ
P.O. es that the igned by t		Part II. Other significant conditi	ons contributing to death	but not resulting	in the underlying cause	given in Part I.	23e. Did to	pacco use contrib	ute to the cause of death?
S, D	ed by	-					1 Yes		Probably 4 Unknown
ord:	plet						24a. Was a autops	sy pri	ere autopsy findings available or to completion of cause of
of Vital Records, ing Physician: The law require Whysician: The law seen sine this certificate has been sineral director, page 2 should be	Completed						perform		eath? ✓ Yes 2 No
tal cian:	Be	25. Was case referred to medical examiner?	43			e of Death (Check			
f Vi Physi er this	۵	1 Yes 2 No 27. Manner of Death	1 Inpatier	nt 2 ER/Out		Other Nursing			
nding nding th.	ë	1 Natural 5 Pend	(Month, Day, Ye	ear)		Yes 2 X No	unk	ow injury occurred	u .
Division tal or Attendir rs after death. al Director: A	icat	2 Accident Inves	stigation FG 11/23		9:24 am 'm, street, factory, office		28f. Location (S	treet and Number	or Rural Route Number, City
Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	Certification:	Outoide	1 nor be		ivate dwell	ing	Baltim	ore, MD	or Rural Route Number, City ICHENTY St
Hosp 24 ho Fune etely f			ysician; To the best of my						
To the Howithin 24 h To the Fur	Medical		miner: On the basis of exam and manner stated.	nination and/or in			t the time, date a		
DONA	Σ	29b Signature and title of certifier	1			se number			(Month, Day, Year)
470	ļ	(landa	bory)		0.0.	.M.E.		November 2	4, 2010
14		 Name and address of person Laron Locke MD. As 	who completed cause of de ssistant Medical Exa	. ,	Penn Street, Balti	more. MD 2120	D1		
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature					
Regist		DEC 02 20	110 Alexander	1. 0					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 4c. County of Death **Physician** ovember 10 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner RROLL GOLDEN NTE ING 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Numbe **Funeral** Months North Carolina 1 M 2 □ F 1950 59 Nov 27, 215-56-0200 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 No Union Bridge Frederick Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21791 11528 B Houck Road USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 ⊆ No Mar-If Yes, Give Year or Dates: Oct 1971 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction Carpenter Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Lester Higgins Maude Sparks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11528 B Houck Road, Union Bridge, MD 21791 Mary Ann Higgins, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Meadow Branch Cem 11/15/2010 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Approximate Interval Between Onset and Death To not enter the mode of wing, such as cardiac or respiratory arrest Enter the disease, or complications that caused the death , or heart failure. List only one caus. , n each line. imme late Cause (Final **Physician** disease or condition resulting in death) /Medical consequence of): Examiner Sequentially list conditions, arry, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Exam that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 No 1 Yes 26. Place of D Check onl one 25. Was case referred t examiner? edical Other: 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 □ ER/Outpatient 3 DOA 4 Nursing Home 2 After this 27. Mann Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No death. after death 2 ☐ Accident in by the 6 ☐ Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral Completely filled in 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier

20125

State Registrar 31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 12, 2010 4:45 a Physician/ Doris Frances Hoffman . Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Long View Nursing Home Carroll Manchester 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Dec 6, 1920 1 - M 2 X Months Days Hours Min Mary Tand 89 Director 220-05-8602 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Westminster Carroll MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21157 1421 Cotton Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Completed by Maryland 21215-0036 ☐ Yes 2 No Specify: Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates 16a, Decedent's Usual Occupation 16b, Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Doulong ည Harry H. Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 1421 Cotton Ct. Westminster, MD Christian R. Hoffman son Baltimore, 11/Pge/2010 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from Owings Mills, MD Gatrison Forest MD VA Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home nature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate snock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph_sician/ disease or condition edical Examiner resulting in death) Due to (or as a consequence of)

ASCV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has page 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ER/Outpatient 3 DOA မ 1 Inpatient 2 I After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending worl after death. 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide

24 hours a

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier (Check

only one)

cause of death (Item 23a) (Type, Print)

d Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month) Day, Year)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOV. **HEDGEPETH** LUCY **AGERTHA** 2010 10:35 A ^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2X F (Month, Day, Year) MAY 23 1 Hours **Director** 225-40-7874 NORTH CAROLINA Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits must be notified MONTGOMERY 1 X Yes 2 No KENSINGTON 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a 3000 McCOMAS AVE. 20895 U.S.A. 1 and 2 should be filed within 72 hours after death f Health and Mental Hygiene. item 27 is marked other than "natural", or items "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ Black, White, etc. 1X Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 3 🗌 Widowed 4 🗀 Divorced If Yes, Give 1 ☐ Yes 2 X No Specify: Completed Year or Dates BLACK other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 CARE GIVER HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CHARLIE HEDGEPETH MAMIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FOSTER HEDGEPETH/SON 4931 BEAUREGARD ST., ALEXANDRIA, VA. 22312 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 ARemoval from State 4 Donation 5 Other (Specify) IVORY HILL CHURCH CEM; 11-19-2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 -M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ oronary Disecse disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): g physician and as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending ph IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 ☐ Yes ∠ ☐ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law certificate 2 PNo 1 Yes 25. Was case referred to medical apleted filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury 24 hours after death. Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 to the F complet 29b. Signature and title of certifier MO 00064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALK DAS GATTHEASBURG, MD 20878

Registrar DHMH 17 Rev 7/2009

State

P.O.

Division of Vital

243 SUMMER

SHARMA

NOV 1 9 2010

31. Date filed (Month, Day, Year)

			For		State	e of Ma	aryland	d / Depa	artment of I	Health	and M	lental Hy	/giene			
			State Registrar					Cer	tificate of L	Death			Reg. No.	2010		38760
Phys M	sicia ledic			Hatsue				Har	rell			2. Date of Domestin Nov 15		Year		Time of Death
Exa	amin	er	4a. Facility Name (if		0	-			4b. City, Town, or Waldo	r Location	of Death		4c. (County of Dea		
Fune	oral		5. Social Security Nu	Wingate	6. Sex	Apt 3	(In vrs. la)	st birthday)	If Under 1 Year	If Under	24 Hrs	0 Data of Di		arles		
Dírec	ctor		212 60 421 Usual Residence of	8	1 □ M 2 X	F	76	Yrs.	Months Days	Hours	Min.	8. Date of Bi Jan 12,	1934	Japa	ountry)	(State or Foreign
land shov	dat	tor	10a. State	10b. County			10c. City,	Town or Loc	ation						10d. Ir	nside City Limits
Mary 28a-f	otifie	Director	Maryl <i>a</i> nd	Charles	3			Wald	lorf							Yes 2 No
with the	ust be n	Funeral D	10e. Street and Num 2001 Wi		urt Apt 3	3			10f. Zip Code	602			0	en of What C	,	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "instural", or items 28a or 28a-f show any initing or other train "instural".	xaminer m	by	11. Marital Status 1 Never Marrie 3 Widowed 4		ied Armed 1 2 Yes,			1f	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	n, Mexican	ı, Puerto F	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit	te, etc.	
hours	cal	lete	-	15. Deceden	t's Education	Dates.			ent's Usual Occup					pecify: Jap		
215 Jin 72 Jan "r	e Med	Completed	(Speci Elementary/Seco	ify only highe	st grade complet	e <i>d)</i> e (1-4 or 5+	.)	(Give k	ind of work done of NOT use retired)	during most	of workin	g		d of Business	,	
d with	Ę I	Be C	12 17. Father's Name (F.					Sea	mstress				G1	enmar Dr	aperi	ies ————
ylanc lid be file Mental P larked o	atic eve	일	UN	KNOWN						18. Mothe	er's Name	(First, Middle, UNKNOWN	Maiden Su	ımame)		
Baltimore, Maryland 21215-0036 Demrit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important if filed 27 is marked other than "natural", on which the man internal, or the page 12 in marked other than "natural".	ler traum		19a. Informant's Nar Ronald	ne/Relationsh Harre11					g Address (Street a) Sirenia P					own, State, Zi	p Code)	
more Page 1 ar nent of Hr int: If iter	no to ki		20a. Method of Dispo 1 XXBurial 2 ☐ 4 ☐ Donation	Cremation	3 ☐ Removal fre	om State	cer	netery, crem	ition (Name of atory or other place	1		ate		ation - City or	,	State
alti emit. I epartm epartm eporta	once.	1	21. Signature of Fund			mol	155	22.	n Cemeter Name and Addres	y IVQV s of Facility	19, 2	Funer	1 Ho	linton,	MID 0.66	22 014
— % & & & & & & & & & & & & & & & & & &	₽ 5I	_	Yess	ica	m.()	mo	ruz	Z AI	<u>exandria</u>	Ferr	y Ro	ad, C1:	inton	MD	2073	
Ph sicia Medi	_		23a. Part 1. Enter the shock, or heart Immediate Cause (F. disease or condition resulting in death)	inal	complications that	at caused to each line.		Do not enter	the mode of dying), such as o	cardiac or	respiratory ar	rest,		Inter	roximate val Between et and Death
Examír	ner	_	Sequentially list con-	ditions	Due t	to (or as a o	conseque	nce of):				1000				
uted nd ransit		Examiner	if any, leading to infin cause. Enter Underly Cause (Disease or iin that initiated events	ring	Dust	lu (or as a s	onsaque	iče vij.								
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687(ertificat Iding ph		ĕ	F FEMALE:				= ==									
ITAI HECOIDS, P.O. BOX 683, sician; The law requires that the death certific certificate has been signed by the attending rector, page 2 should be detached for use as		Physician/M	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☑ 9 ☐ Unknown	onths?		/e Birth⊸2 egnant at ti	☐ Fetal c	death 3 🗌	Ectopic pregnancy Other (specify)	/	<u>. </u>		23	d. Date of del Month	livery Day	Year
T.C. that the gned by e detact	İ	S P	Part II. Other signific	ant condition	s contributing to	death but	not result	ing in the un	derlying cause give	en in Part I.		23e. Did to	bacco use	contribute to	the caus	se of death?
rds, equire: een sig nould b												1 🗆 '	res 2□	No 3 □ Pi	robably	4 Dunknown
OT VITAI KECOTGS, II Physician: The law requires ter this certificate has been sig neral director, page 2 should b		Completed										24a. Was a autop perfor	med?	24b. Were aut prior to death? 1 \(\sum \) Yes	completion	dings available on of cause of
I tal ician; sertific ector,		a a	25. Was case referred examiner?		Hospital:					ce of Death	(Check c		ZZINO			10
Physical chiral	- 1	2	1 Wes 2	No	1			Noutpatient		4 ⊔ Nur	sing Hom	e 5 Resid	ence 6 🗆	Other (Speci	ify)	
ION O tending leath. or: After the funer		Certificate	1 Natural 2 Accident	5 Pending Investiga 6 Could no	tion (Mo	e of injury onth, Day, Y	/ear)	Bb. Time of injury	28c. Injury work?		- 1	d. Describe h	ow injury o	ccurred		
LIVISION ital or Attendir as after death. al Director: Afted in by the full			4 Homicide	determin	ed 28e. Plac	ce of Injury ding, etc. (\$	- At home Spec <i>ify)</i>	e, farm, stree	t, factory, office		28	f. Location (S City or Tow		umber or Rur	al Route	Number,
DIVISION OF VITAI HECC To the Hospital or Attending Physician; The law within 24 hours after deach. To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s		Medical	(CiteUK Zue	Liviedicai Ex	aminer: On the b	asis of exar	nination ar	nd/or investig	cured at the time, o ation, in my opinion ath occurred at the	death acc	urrod at th	a tima data ar	d plaga on	d due to the e	- 1-1-01	ind manner stated.
To t With			9b. Signature and titl	e of certifier					29c. License r	number			29d. Date s	igned (Month	, Day, Ye	1
2 111		.9	0. Name and address	s of person wh	no completed car	Ise of deat	h (Item ??	la) (Type Pri-	D00				-	/ /7		
N58			1. Date filed (Month,	14. Te	Cons. n	V V	116	55 W	We Sup	BC (La Pl	ula n	0 2	0646		
Regis	State strar		Date filed (MORRI),	10V 19	2010 32.	Hegistrar's	Signature	B. 190	ake							

		•	1 - State of Maryland / Dep	artment of Health an	nd Mental Hy	/giene	10 38761
			Decedent's Name (First, Middle, Last)		2. Date of D	eath	3. Time of Death
	Physicia		Robert Wright Hamblin		Nov.	19, Day 20	10 9:37 a ^M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of D	Death	4c. County	
	į	•	Holy Cross Hospital	Silver Spr:	ing	Mont	gomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24		rth	9. Birthplace (State or Foreign
	Director		215-38-5879 ^{1™M2□F} 69Yrs.	Months Days Hours	Jan T	7, 1941	Country) D.C.
	*		Usual Residence of Decedent				
	land f sho	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a- otifie	irec		yattsville			1 🗆 Yes 2 🔀 No
	a or be n	al D	10e. Street and Number	10f. Zip Code		10g. Citizen of	What Country?
	nust	Funeral Director	10805 Bornedale Drive	20783		USA	
	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at		Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)		ce - American Indian, ck, White, etc.
ဗ္	after ", or cami	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Var or Dates	1 ☐ Yes 2 🗷 No Specify:			White
Ş	ours attura	Completed by	Total of Dates.	dont's House Cooungtion		1	
က်	72 hc n "ne ledic	du	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of OO NOT use retired)	working	16b. Kind of B	Business Industry
12	ithin ene. • thal	ပ္ပ	Elementary/Seconday (0-12) College (1-4 or 5+)	C.P.A.		Own .	Business
N O	Hygi Hygi other	Be (17. Father's Name (First, Middle, Last)		Name (First, Middle		
an	be fil set al ked c	၉	Jack Arthur Hamblin	Ma	argaret	Wright	,
Ξ	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number o	r Bural Boute Numb	er City or Town. S	State, Zip Code)
Š	2 sh Ithar 27 is rtrau			,			ring,MD 20905
Baltimore, Maryland 21215-0036	and Hea Item		20a, Method of Disposition 20b, Place of Disp		v^{Date} 22,		- City or Town, State
o L	age 1		1 Burial 2 Cremation 3 Removal from State cemetery, cre 4 Donation 5 Other (Specify) Metropo	matory or other place) No litan Cremato	ov. 22,	77	
₫	artme artme ortan injur	13					
Ř	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		100 415470110	2.Name and Address of Facility rancis J. Co: 0 University	llins Fu Blvd. W	neral : ., Sil	Home Inc. ver Spring,MD
ø			23a, Part 1. Enter the disease, or complications that caused the death. Do not en				Approximate
	nysician/	5 8	shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Arter	v Disease			Interval Between Onset and Death
	Medical		disease or condition resulting in death) Due to (or as a consequence of):	, biscase			months
	Examiner						
		ner	Sequentially list conditions, if any, leading to immediate				
	Ausit ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury				
	be executed sician and burial-transi	ŭ	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
9	icate be executed physician and is the burial-transit	dical	d				
3/6	certificate anding physuse as the	Med	IS SEAME.				
89	endin sudin	an/l	IF FEMALE: 23b. Was decedent pregnant 1	Ectopic pregnancy		23d. Da	ate of delivery
Rox	death he atte ed for	sicia	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Mo	onth Day Year
0	that the c ned by the detache	Physician/Me	9 Unknown				
		by F	Part II. Other significant conditions contributing to death but not resulting in the Hypertension, Diabetes Melli		1		tribute to the cause of death?
ds,	quires en siç suld b	ted	mypercension, blabeces Melli	cus,	_ 1∟	Yes 2 □ No	3 Probably 4 Unknown
Division of Vital Records,	law requires nas been sign e 2 should be	Completed	Prostate Cancer, Sleep Apnea	, Hypothyroic		s an 24b.	Were autopsy findings available prior to completion of cause of
ě	sician: The law I certificate has k lirector, page 2 s	νοχ			_ per	ormed?	death? 1 Yes 2 No
a	Physician: The rthis certificate haral director, page	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)		
=	nysic iis ce direc	2	1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2 X ER/Outpatie	nt 3 DOA Other: 4 Nursi	ng Home 5 ☐ Res	idence 6 🗆 Oth	er (Specify)
0	ng Pt ter th neral		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)	of 28c. Injury at work?	28d. Describe	how injury occurr	red
on	endir sath. or: Af he fu	tica	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No			
<u> S </u>	r Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		Street and Numb wn, State)	per or Rural Route Number,
ā	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,						
	Hosp 14 hot Funel ted fill	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inverse.)	stigation, in my opinion, death occur	rred at the time, date	and place, and du	ie to the cause(s) and manner stated.
	the I	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	death occurred at the time, date an		he cause(s) and m	anner as stated.
_	P M P		29b. Signature and title of certifier	29c. License number			ed (Month, Day, Year)
D	5		Ar whod not run M	D57630	J	Nov.	19, 2010
			30. Name and address of person who completed cause of death (Item 23a) (Type, Anuradha Arun, MD 10301 G	Print) eorgia Ave.,	Silver	Spring	, M D
	Sta ⁻	e	31 Date filed (Month Day Year)			1 3	
	Registra		31. Date filed (Month, Day, Year) 12. Registrar's Signature 12. Registrar's Signature 13. April 14.	les .			

			For State Registrar	State of M	aryland		artment of F tificate of L		nd Mental Hy	giene Reg. N	2010	3876	2
	Dhuaisia	- /	Decedent's Name (First, Middle	le, Last)					2. Date of Dea	ath		3. Time of Dea	
	Physicia Medic		Webber Douglas						Novemb	$\overline{}$	ľ8, 2ďľo		М
	Examin	er	4a. Facility Name (If not institution Glade Valley Nu	-	h Cen	ter	4b. City, Town, or Walkers		Death	4	c. County of Deat Frederi		
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last		If Under 1 Year	If Under 24		h ,	9. Birt	hplace (State or For	eign
н	Director		504-09-3615	1 ⊠ M 2 □ F	9	3 Yrs.	Months Days	Hours	Min. (Month, Day August	9 , 1	917 Minr	^{intry)} lesota	
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County	/	10c. City, 7	Town or Loc	cation					10d. Inside City Li	nits
	faryla Ba-f s tified	Director	Maryland Fred	lerick		Myers	ville					1 ☐ Yes 2 🛣	No 18
	a or 2		10e. Street and Number				10f. Zip Code				itizen of What Co		
	th with	Funeral	10323 Clark Roa				21773			Un	ited Sta		
' 0	e filed within 72 hours after death with the Maryland tral Hygiene. So dether than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Ma	12. Was Decedent B Armed Forces? rried 1 ***X*Yes 2 **		13, V	Vas Decedent of H Yes, specify Cuba	ispanic Origin ın, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)		14. Race - Ame Black, White		
903	ırs afte ıral", I Exar	ed b	3 ₩ Widowed 4 □ Divorce	If Voc Civo	WWII	1	☐ Yes 2 🔀 No	Specify:			Specify: Whi	ite	
15-(72 hou • "natu edica	Completed		ent's Education est grade completed)	Ţ	(Give I	ent's Usual Occup	ation during most o	f working	16b.	Kind of Business	Industry	
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bu	filed wall Hyg	Be	17. Father's Name (First, Middle,	•					s Name (First, Middle,		,		
yla	uld be Ment narke	입	Herman Harrison						Josephine				
Maryland 21215-0036	of and 2 should be file of Health and Mental Health and Mental Health 27 is marked or other traumatic eve		19a. Informant's Name/Relations Larry D. Jar1						or Rural Route Numbe ${ t Silver Sp}$				
ē,	f Heal f Heal item 2		20a. Method of Disposition			ce of Dispo	sition (Name of		v. 19,		Location - City or		
mo	Page 1 nent of l ant: If it ury or o		1 Burial 2 K Cremation 4 Donation 5 Other		1		natory or other place n Cremato		2010	Fre	derick,	Maryland	
Baltimore,	permit. Page Department of Important: If any injury or		21. Signature of Fur eral Service	Zicensec		22 R 9	Name and Address esthaven 501 Cato	ss of Facility Funer ctin M	al Service ountain Hw	s, y.	Skkot Co Frederic	dy P.A. k, MĎ 217	01
			23a. Part 1. Enter the disease	or complications that caused only one cause on each line	the death.							Approximate Interval Between	
- 7	Pnysician/		Immediate Gause (Final disease or condition	_ Basal Ga		CVA					i.	1 Week	'n
	Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):							
		je.	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequer	nce of):							
	uted Id ansit	ami	cause. Enter Underlying Cause (Disease or iinjury that initiated events	G									
	e exectian anurial-tr	edical Examine	resulting in death) Last	Due to (or as	a consequer	nce of):							
760	icate be executed physician and sthe burial-transit	edic		d									
89	certific nding use as	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pregnanc				23d. Date of de	livery	
Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a			Other (specify)	-y			Month	Day Year	
	at the od by t detach		Part II. Other significant condit	ions contributing to death b	out not result	ting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco	use contribute to	the cause of death	?
S, F	v requires that s been signed t should be det	ed by	Dementia						1 🗆	Yes 2	2 🔀 No 3 🗆 P	robably 4 🗌 Unki	nown
ord	w requ	Completed							24a. Was		24b. Were au	topsy findings availa	able
Rec	The law arte has page 2 s	Som		,					perfo	rmed?	death?	2 No	, , ,
tal	ician: The certificate ector, pag	Be	25. Was case referred to medica examiner?	Hospital;			26. Pl		(Check only one)				
Ϋ́	ding Physician: h. After this certific funeral director,	일	1 ☐ Yes 2 ★★ No 27. Manner of Death	1 ☐ Inpati		R/Outpatier 8b. Time of	t 3 LI DOA	4XXI Nurs	sing Home 5 Residence Residence Page 1			rify)	
ou c	nding ath. r: Afte ie fune	icate		tigation	y, Year)	injury	work	ć? Yes 2□N	ı				
Division of Vital Records, P.O.	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	d not be mined 28e. Place of Inju- building, et	ury - At hom c. (Specify)	e, farm, stre	eet, factory, office		28f. Location (S City or Tox			ral Route Number,	
۵	spital ours a ours a leral D		29a. Certifier 1 🛣 Certifyin	g Physician: To the best of	my knowled	dge, death o	occured at the time	. date and pla	ace, and due to the ca	use(s) a	and manner as sta	ated.	
	n 24 h	Medical	(Check 2 Medical	Examiner: On the basis of e g Nurse Practioner: To the	xamination a	and/or invest	tigation, in my opinio	on, death occu	urred at the time, date a	and plac	e, and due to the	cause(s) and manner	stated.
	To the vithing to the common c	_	29b. Signature and title of certific	ər			29c, Licens	e number			ate signed (Montl		
			MA			2 > =	D 265	16		Nov	ember 19	, 2010	
"7	TIVA		30. Name and address of person Allen J. Gilso					rick.	MD 21702				
	Sta	te	31. Date filed (Month, Day, Year)				parker	,					
	Registra	ar	NUV	10 CO 10 /ch	Minister	p.	SCHOOL STATE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 2:00 <u>November</u> Medical Mimi Kliegman 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fairfield Nursing Home Crownsville Anne Aroundel 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year 10/04/1934 1 🗆 M 2 🗓 F Min **Director** Yrs. 577-44-8506 Usual Residence of Decedent or 28a-f shov 10a, State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Crownsville MD <u>Anne Aroundel</u> 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21032 1454 Fairfield Loop Rd . Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 N No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates White injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than Executive Secretary Software Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jack Greenbaum Sadie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 2, any injury Cheryl King / Daughter <u> 20409 Ivybridge Ct. Gaithersburg, MD 20886</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA David Mem. Grdns: 11/12/2010 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc 21. Signature of Funeral Service Licens 1091 Rockville Pike Rockville MD 20852 20a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) to (or as a consequence of **Examiner** Sequentially list conditions, if any cause government accuse. Enter Underlying Cause (Disease or iinjury that initiated events tue to (dras a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 Tho 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 1 No Yes 2 1 No 1 Tyes **Division of Vital** Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

e Funeral Director; Aft oleted filled in by the fur 2 🗌 No 2 Accident
3 Suicide
4 Homicide 1 Tes Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in this opinion, usual occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2.

State Registrar

29b. Signature and title of certi

31. Date filled Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

208

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day James Urban Kordenbrock 17 2010 Nov. 1:15p Medical 4a. Facility Name (if not institution, give street and number) Renaissance Gardens 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring P.G. at Riderwood Village Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 7, 1 9. Birthplace (State or Foreign **Funeral** 1**★** M 2 □ F Months Davs Hours Min. Director 270-16-9973 91 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2X No M D Montgomery Silver Spring 10e. Street and Number ō 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral Gracefield Road, #121 20904 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ò ģ 2 No 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White "natural" Year or Dates. 1942-46 3 Divorced 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)
5 + h and Mental Hygier 7 is marked other t Aeronautical Engineer U.S. Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Urban Henry Kordenbrock Marie Catherine Kelly permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3124 Gracefield Rd., #121, Silver Spring, Md Ann E. Kordenbrock/ Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Nov. 20 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Silver Spring, MD 4 Donation 5 Other (Specify) 2010 Cemetery of Funeral Service Licensee Signature Taned some inc. & CM9 500 University Blvd. Silver W . . Spring, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final Onset and Death Pnysician. Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the ' use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Pregnant at time of death 5 Other (specify) Year been signed by the sahould be detached 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Atrial Fibrillation Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed Hospital or Attending Physician: The certificate 2 \square No Yes 1 Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🍱 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending neral Director: A 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 2 29d. Date signed (Month, Day, Year)

State Registrar Gracefield Road, Silver Spring,

3160

legistrar's Signati

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Eileen

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Melva Ruehlmann Kistler 18, 2010 November 9:15 A^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery 4016 Oliver Street Chevy Chase If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Country) Ohio 1 □ M 2**X** F Hours 0 991 87 1 917 272-12-3620 Director 93 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery Chevy Chase 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 20815 10g. Citizen of What Country? United States 4016 Oliver Street Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ♥ Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Peter Ruehlmann Edna Geisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5511 Park Street Chevy Chase, MD 20815 Pam Booth / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/19/2010 National Crematory Falls Church, VA 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral S 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Respiratory Failure Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of): ithin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and supplied filled in by the funeral director, page 2 should be detached for use as the burial fransi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 [] 3 [] (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) November 18, 2010 D0065214 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lisa McGrail MD 5454 Wisconsin Ave. #1300 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial XX Cremation 3 Removal from State 4 Donation 5 Other (Specify)	osition (Name of matory or other place) Nov. litan Crematory	te 22,	20c. Location - City or Tow	
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Hoon	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check Check Ch	tigation in my opinion death occurred at the	time date and	d place and due to the series	e(s) and manner stated
r the	within To the comple	— г	only one) 3 Certifying Nurse Provioner: To the best of my knowledge, 129b. Signature and title of certifier	death occurred at the time, date and place, a 29c. License number	and due to the	cause(s) and manner as state 9d. Date signed (Month, Da	d.
	2		> Ly Rosech	D09834		Nov. 22, 2	
			30. Name and address of person who completed cause of death (Item 23a) (Type, F Barry Rosenbaum, MD 3720 Far	rint) Cragut Ave., Ken	sinata	n. MD 2000	3.5
(34) (3)	State	9	31 Date filed (Month Day Year)			on, no 2005	
	Registra	r	NOV 23 2010 Lance A. Aca				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month NOVEMBER ^{ay}20 SOON HEE 8:05 A M LEE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yea Jan 14,] **Funeral** 7. Age (In yrs, last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Korea 1 □ M 2 🛣 F Days Min. Hours Director Yrs <u>217-08-1238</u> Jan. Usual Residence of Decedent or 28a-f shov notified at 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Frederick <u>Frederick</u> 10e. Street and Numbe 10f. Zip Code ms 23a or must be i 10g. Citizen of What Country? Funeral 7601 San Di Gan Drive USA 21702 items ? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner 1 Never Married 2 Married ö Black, White, etc. þ 1 ☐ Yes 2x No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: "natural", 3 Divorced Completed Specify: Year or Dates Asian the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 2 homemaker own home t of Health and Mental Hygi If item 27 is marked other or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည unknown Sang Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7601 San Di Gan Drive, Frederick, MD 21702 <u>Kun Yong Lee / Son</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Yellow Springs Cemetery 11/24/10 4 Donation 5 Other (Specify) Frederick, MD 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signatur 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one car Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) X LETUS IS Correnany YEARL Medical Examiner ABETES YEMMI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or): ned by the attending physician and detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No Pregnant at time of death Month Day Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performed this certificate 2 No 2 **N** Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖳 No 2 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after ucco....
To the Funeral Director: After this 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending ☐ Accident☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/21-2010 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701 TREDERICK A.KAZMI, Mr つけてに House 814 31. Date filed (Month, Day toll Registrat's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amended #1 per MD, RG FCHD 11/30/10 30/10 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Lawso 0612 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Jan. 12 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Birthpica Country) MD Year) 1929 1 □ M 2**X** F Months Days Min. Hours Director Yrs Jan. 81 213-24-8566 Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits notified 28a-f 1 Yes 2X No MD Washington Hagerstown ms 23a or must be n ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21742 <u>424 Village Place</u> filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. ö 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural". 3 Widowed 4 Divorced Specify: Completed Year or Dates White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I မ Wilbur Smith Gertrude Dutrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health Robert Sherald-son 13181 Delaware Circle, Waynesboro, PA 17268 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Olivet 11/24/2010 Frederick, MD 21. Signature uneral Service Licen 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 Fart 1. Enter the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate erval Between Immediate Cause (Final Onset and Death [©]hysician/ tine disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? for Day Month Year Pregnant at time of death 5 Other (specify) i signed by the a ld be detached f 1 Yes 2 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, ïcate has been siç r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed certificate Yes 2 N ieral Director: After this certific filled in by the funeral director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Depatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natura 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the I within 2 only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) (ahma l 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5'80 Northern Auc Mahwood

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

2010 Registrar's Signature

			For State Registrar	State of Ma		artment of Hea tificate of Dea			21111	38770
			Decedent's Name (First, Middle, Last,			imedic or bed		2. Date of Death	ı. No.	3. Time of Death
	Physicia Media		Catherine	Tilp	Luther			Month November	Day Yea 10, 201	r
	Examir		4a. Facility Name (if not institution, give s			4b. City, Town, or Loca		NO VEMBER	4c. County of D	
			Shady Grove Adven			Rockvill	e		Montgo	mery
	Funeral Director		5. Social Security Number 6. Sex	7. Age ((In yrs. last birthday) O7 Yrs.		nure Min	B. Date of Birth (Month, Day, Ye July 19,	9. i	Birthplace (State or Foreign Country)
			579-07-4479 Usual Residence of Decedent		97 Yrs.			July 19,	1913 Wa	shington, DC
	iand shov dat	to	10a. State 10b. County	1	10c. City, Town or Loc	cation			,	10d. Inside City Limits
	Mary 28a-1 otifie	irec	Maryland Montgome	ery	Gaither	sburg				1 🗌 Yes 2 🔀 No
	th the	a D	10e. Street and Number			10f. Zip Code		100	. Citizen of What	Country?
	within 72 hours after death with the Maryland glene trhan "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	Funeral Director	8621 Calypso Lane			20879			United	States
(0	or ite	by F.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🔀 No	If	Vas Decedent of Hispani Yes, specify Cuban, Me	ic Origin? (Specit exican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ar Black, Wi	merican Indian, nite, etc.
ဗ္ဗ	s afteral",	b b	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		☐ Yes 2 🔀 No Sp	ecify:		Specify:	White
2-0	hour "natu dical	Completed	15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usual Occupation		16	b. Kind of Busines	
2	hin 72 ne. than	E O	Elementary/Seconday (0-12)	College (1-4 or 5+)	Ìife. DC	ind of work done during NOT use retired)	i most ot working			
Ż	dygie ther nt, th	Be	12 17. Father's Name (First, Middle, Last)		Hon	nemaker			Own Hom	e
au	be filed ental Hyg ked oth ic event,	일	,	T m21		18.1	Mother's Name (F	First, Middle, Maid	_	
کے	12 should be file alth and Mental I 27 is marked o r traumatic eve		Harry I 19a. Informant's Name/Relationship (Typ)	H. Tilp		g Address (Street and N	humban an Dunal F	Clara	Beckma	
Š	d2sh alth a 127is ortrau		Dennis R. Luther/So	,		Calypso Lan				
re,	of Heal of Heal fitem 2		20a. Method of Disposition		20b. Place of Dispos	sition (Name of	Dat		c. Location - City	
<u><u>E</u></u>	Page 1 nent of ant: If it ury or o		1 🔀 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			atory or other place) ln Cemetery	11/17/	2010 B	rentwood	. Marvland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Hygiene. D		Service License		22.	Name and Address of F	acility DeVo	1 Funera	al Home	,,
_	<u>00 = 6 €</u>		Medicus	1 Leve		East Deer			ersburg,	MD. 20877
			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only one	cause on each line.	ne death. Do not enter			espiratory arrest,		Approximate Interval Between
~P	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	ASOI	ratio	n, tern	ninal			Onset and Peath MINUTES
-10/2	Examiner		T and the second	Due to (or as a c	onsequence of):	,				
		ner	Sequentially list conditions, but if any leading to immediate	Due to (or as a a	onstiguence city				-	
1	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury							
	be executed sician and burial-transi	Ĕ	that initiated events c resulting in death) Last	Due to (or as a co	onsequence of):					
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ळू	ling p	Me	IF FEMALE:					_		
	ath ce	Physician/Me	in the past 12 months?	ic. If yes, outcome of p	☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date of d	,
PO	the a	ıysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at tir 9 ☐ Unknown	me of death 5 🛄	Other (specify)			Month	Day Year
53	led by detai	by Pt	Part II. Other significant conditions conf			derlying cause given in I	Part I.	23e. Did tobaco	co use contribute	to the cause of death?
S	n sign	ed b	alzheimers di	ementia	_			1 ☐ Yes	2 🗆 No 3 🗔	Probably 4 🔀 Unknown
eoords,	s bee	Completed	seizures					24a. Was an	24b. Were a	utopsy findings available
e P	ate ha	E	depression					autopsy performed 1 Yes 2	l? death?	es 2 No
1 4 1 4 1 5 7	ertifica	Be	25. Was case referred to medical			26. Place of	Death (Check on		INOL ICH	es 2 🗆 NO
5 ₹	this a	욘	1 🗌 Yes 2 🔀 No		2 KER/Outpatient	3 DOA Other: 4	☐ Nursing Home	5 Residence	6 Other (Spe	ecify)
	After funera	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	28b. Time of injury	28c. Injury at work?		I. Describe how in	jury occurred	
	deatl ctor: y the	Ęį Į	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injuny	- At home, farm, stree	M 1 Yes			:	
	Dire	ğ	4 Homicide determined	building, etc. (S	Specify)	st, factory, office	281	City or Town, St.	and Number or R ate)	ural Route Number,
NUC'	hours hours d fille	edical	29a. Certifier 1 Certifying Physic	an: To the best of my	knowledge, death oc	cured at the time, date a	and place, and d	ue to the cause(s)	and manner as s	tated.
Tou.		≥	only one) 3 Certifying Nurse	r: On the basis of exam	nination and/or investic	ation, in my opinion, deal	th occurred at the	time date and no	are and due to the	cause(s) and manner stated
Ė	No To Con		29b. Signature and title of certifier		1	29c. License numb	oer C		Date signed (Mon	
	1/		1/well 1	melle	1 MO	1000	70 17		11101	2010
-			30. Name and address of person who com	1	h (Item 23a) (Type, Pri 1901 – Med	ical conto	Ic Diciola	Parkisi	le Man	land 20850
	State	9	31. Date filed (Month, Day, Year)	3. Registrar's		i d	Urive	ruck VII	ic/ relary	1.1.
	Registra	-	NOV 17 2046	Carried and	A. Asaul	1/2				
	17 Rev 7/200									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LEE HUI 7/37 AM 010 11 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 18889 Waring Station Road, #317 Germantown Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours **Director** 219-92-7014 01/25/1939 Korea Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛛 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18889 Waring Station Road, #317 by Funeral 20874 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, 11. Marital Status within 72 hours after 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker h and Mental Hygie Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o any injury or other transcent Heun Jong Kwak 2 Soon Young Yang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 19a. Informant's Name/Relationship (Type. Print) 18889 Waring Station Road, #317, Germantown, In Lee - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【I Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 11/22/2010 Brentwood, Maryland 21. Signature of Fineral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) Stomach with Liver Meter **Physician** them cencinoma /Medical Due to (or as a consequence of): Examiner Secuentially list continuity if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day Year 5 ☐ Other (specify) P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform Hy force the 25. We e referred to medical examiner? tremia Division of Vital 1 ☐ Yes 2 No 2 No director, 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 124 hours after death.
e Funeral Director: A letely filled in by the fu 1 □Yes 2 □No 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifie 29c. License number 5 29d. Date signed (Month, Day, Year) MD: 30. Name and address of person who completed cause of death (Item 23a) (Type ca Ly Grove Rd Suite 100,

State

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH g911 1/05/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ N%♥.19,2010 Daniel 6:45a Lazaro Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Dec 2, 1932 **Funeral** cial Security Number -9-26-0077 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 070 070 Days Hours 1 🔀 M 2 🗆 F N.Y., N.Y. 77 Director Usual Residence of Decedent shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland at Director ems 23a or 28a-f sh r must be notified a MD Montgomery Germantown 1 🗆 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18003 Mateny Road #422 20874 USA "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S.
Armed Forces? 1 953
1 2 Yes 2 No 1 955
If Yes, Give 1 955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Architeture Architectural Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Dorotea Fole David Lazaro ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Sasselli/daughter 13209 Webster Hill Way Clarksburg, MD. 20871 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Rep Ivy Hill Crem. 11/24/2010 Philadelphia,Pa 4 Donation 6 Other (Specify) 21. Signature of Fig eral Service Lice PHILIP dd D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Bladder Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to himself cause. Enter Underlying Date to for es a nonsecuer de ofiattending physician and for use as the burial-transit Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed metastesis to the lung, liver and spine 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ours after death.

eral Director: After this certificate has filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 X Other (Specify) OSPICE 1 Tes 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 5 Pending injury 1 XNatural ...vatural
Accident
Suic work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital To the Hospital within 24 hours a To the Funeral Completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10 R 143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road Rockville, Md. Deborah Miller CRNP

State Registrar 31. Date filed (Month, Day

. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov 2010 4:00 A Michael Lucas Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Sykesville Copper Ridge Assited Living If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 X M 2 □ F 93 Hours July 22 Director 188-09-4272 PA 1917 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 X No Clarkesville MD Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21029 13320 Wicklow Place United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1
Yes 2 ☐ If Yes, Give Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WWII "natural", 3 X Widowed 4 Divorced Specify. White Year or Dates the of Health and Mental Hygiene.

If item 27 is marked other than "nature or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Tose Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bertha Lucas Charles Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13320 Wicklow Place Clarkesville, MD 21029 Barbara Swales (Daughter) Page 1 and 2 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🛣 Burial 2 □ Cremation 3 🙀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Michael Cemetery 11/16/2010 Mont Clare, PA Signature of uperal Service License Burrier-Queen Funeral Home and Crematory, P.A. 1212 W. Old Liberty Rd. Winfield. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ementia Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) Hospital: 2 🗆 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 🗹 Natural injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completed filled in by the fu Accident Investigation ☐ Acciden ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL (1 14+IVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			Please	Type or Print in I				_		Legible.	
			For State	State of Marylan	•	artment of I tificate of I			9	nin	20775
	Physicia		Registrar 1. Decedent's Name (First, Middle, Las	Solomon Noa)eaiii	2. Date of Dea		, 2010	3. Time of Death 8:00 P M
Ē	Medie Examir		4a. Facility Name (if not institution, give			4b. City, Town, o	r Location of Death		4c. C	County of Death	
	Funeral Director		5. Social Security Number 6. S			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird	th	g. Birth	place (State or Foreign
	ryland -f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County		, Town or Loc	r Spring					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	with the Ma 23a or 28a ist be notif	Funeral Director	Maryland Montgom 10e. Street and Number 901 Arcola Aven	-	31146	10f. Zip Code	20902			en of What Coult	ntry?
980	e fled within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Anned Forces? 1 1 Yes 2 No If Yes, Give Year or Dates.	lf	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Americ Black, White, pecify: Whi	etc.
Baltimore, Maryland 21215-0036	within 72 hour giene. ner than "natu t, the Medical	Completed by	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)		(Give k	lent's Usual Occup kind of work done O NOT use retired) re d'	ation during most of work	king		of Business In	
/land	vuld be filed wit d Mental Hygie marked other matic event, th	To Be	17. Father's Name (First, Middle, Last) Moshe Chaim Lev	inson			18. Mother's Nam Tikva	ne (First, Middle, Rachel			
, Mar	2 sho th an th is		19a. Informant's Name/Relationship (7 Ira Starr, Neph	ew	1		ircle, Fa				
timore	G F F F		20a. Method of Disposition 1 Derivation 3 Capacitan 4 Donation 5 Other (Special Control of Capacitan Capa	Removal from State (fy) Mt.	_{emetery, crem} Leban	sition (Name of patory or other place on Cemet	ery 11/1	Date 9/10	Adel	ation - City or To	
Ba	permit. Departr Imports any inj		21. Signature of Juneral Service Licen	NOIDE		reninsky 4 Carrol	ss⊭eets⊮ew f 1 St., NW	·uneraı I, Washi	ngtor	n, DC 2	20012
-	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		Diseas		g, such as cardiac	or respiratory arr	rest,	!	Approximate Interval Between Onset and Death O Years
.60	ate be executed bhysician arterial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence) d.							
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral <u>Jirector</u> . After this certificate has been signed by the attending physis completed filled in by the funeral director, page 2 should be detached for use as the L	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnat 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 🗔	Ectopic pregnand Other (specify)	ру		23	d. Date of delive	ery Day Year
ls, P.O	uires that the signed by ald be detact	by	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the ur	nderlying cause gi	ven in Part I.				ne cause of death?
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of V	g Phys er this eral dir	e: To	1 Yes 2 No 27. Manner of Death	1 L Inpatient 2 L	28b. Time of	28c. Injur	4 LX Nursing He	ome 5 Resid)
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	1			Yes 2 No	28f. Location (S City or Tow		Number or Rural	Route Number,
Δ	he Hospital in 24 hours he Funeral pleted filled	Medical	(Check 2 Medical Exam	sician: To the best of my knowle iner: On the basis of examination se Practiciper: To the beside my	and/or investi	igation, in my opinio	on, death occurred a	t the time, date a	nd place, ar	nd due to the car	use(s) and manner stated
	20+1		29b. Signature and title of control	Kouch)9834		Nove	signed (Month, I mber 18	
	~ '		30. Name and address of person who a Barry N. Rosen			ragut Ave	e., Kensi	ngton,	MD 2	0895	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	Rad					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 13, Physician/ Saul Levine 2010 06:05 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Min. Months April 28 New York Hours Director 113-01-5658 Yrs 95 Usual Residence of Decedent ms 23a or 28a-f show must be notified at filed within 72 hours after death with the Maryland al Hygiene.
d other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Florida Broward Pembroke Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12955 SW 16th Court M103 33027 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces' þ 1 Never Married 2 Married 1 ★Yes 2 No 1943
If Yes, Give 1945 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Salesman Furniture 27 is marked other traumatic event, Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve once. Menta ပ Harry Levine Sarah Barshak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Levine/Son 4009 Mansion Drive, NW. Washington DC 20007 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Menorah Gardens Cem. 11/16/2010 Southwest Ranches, FL 22. Name and Address of Danzansky-Goldberg memorial Chapels. mo1597 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Cardiorespiratory Arrest Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Hypoxia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit Urosepsis that the death certificate be executed and Due to (or as a consequence of): physician Physician/Medical Box 68760 as the l attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death Day ed by the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? by Records, The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available 24a. Was an has autopsy performer prior to completion of cause of death?

1
Yes 2
No Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 12 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and little 29c. License number 29d, Date signed (Month, Day, Year, D70241 November 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shanthi Nadar, MD 2150 Pennsylvania Avenue, Suite 5-411, Washington DC 20037 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#19coerINF, 11/29/10, BWW, Mcco Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20/9 Physician/ Month 0836M aw son ane Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Deat Soring 3510 E 9 mon Somes 36 Social Security Number 8. Date of Birth (Month Day Year) Dec. 2, 1923 Age (In yrs. last birthday, If Under 24J/rs. Funeral 9. Birthplace (State or Foreign PAntry) 86 Director 199-12-0762 Usual Residence of Decedent 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Montgomery Silver Spring 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 USA 3510 Forest Edge Drive, Bldg. 16, Unit 2D 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. à 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ₩ Widowed 4 □ Divorced Specify. White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Baltimore, Maryland 21215-permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene Important. If item 27 is marked other than "ns any injury or other traumatic event, the Media (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Residential Rental Assistant Resident Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ David E. Bannon Margerum L. Ellsworth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
713 Kearney-Road, Silver Spring, MD 20902 19a. Informant's Name/Relationship (Type, Print) William Edward Burgess/Executor 20a. Method of Disposition 20b. Place of Disposition (Name of Noy Date 27 20c. Location - City or Town, State cemetery, crematory or other place)
Cate of Feaven Cemetery 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Ineral Service Lice Francis d'ddress 11 Francis Funeral Home Inc. tan 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 month 1 Yes 2 No Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: poleted filled in by the funeral director. 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Jo L 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Division s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certific 29c. License number MD OME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anxes6 31. Date filed (Month State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ MULLER Month CATHY ELLEN 10:38 A M NO 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UDIVERSITY OF MARYLAND MEDICAL CONTER BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) May 9, 1948 9. Birthplace (State or Foreign Country) Michigan Funeral 1 M 2 X **Director** 62 367-50-9409 28a-f show 10b. County 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 8814 Sandrope Court 21046 United States 11. Marital Status . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. the Medical Examiner Yes 2 No Black. White, etc. ģ 1 Never Mamied 2 Married 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked of should be Sylvester Robert Carney LaVergne Α. Bertran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Muller/husband 8814 Sandrope Court Columbia, Maryland 21046 Page 1 and 2 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. inal Journey Crematory 11/24/2010 Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Thomas M00957 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final Onset and Death Physician/ complete high sonal cord Medical resulting in death) CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami Due to (or as a consequence of) physician s the burial Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
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2 Accident
3 Suicide injury 5 Pending 1 Yes 2 No NOV 13 2010 tall from horse Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10400 Gorman Road 4 Homicide determined building, etc. (Specify) Horse Farm 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

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Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

Registrar DHMH 17 Rev 7/2009

State

only one)

31. Date filed (Monti

29b. Signature and title of certifie

NO

BILGEDICIE KALYON, MD 22 SOUTH GREENE ST, BALTIMORE, MD 21201

32. Rigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

P25607

NOV 17 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No_ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month D)a1 18,2010 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospita Adventist Rocky. Ne Montgomer Grove If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 □ F Months Min. May 10, Days Director 132-12-8054 Yrs 1918 Pennsylvania 92 Usual Residence of Decedent 10b. County 10a, State with the Maryland 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 28a-f 1 ¥ Yes 2 □ No Maryland Montgomery Gaithersburg 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 217 Booth Street 20878 United States permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. "natural", or items Important; if item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1939-65 1 ☐ Yes 2 No Specify. White 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Soldier U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Martyniuk Maria Stefanik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9003 Bush Creek Circle Frederick, Maryland 21704 William P. Martyniuk / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Barnesville, Maryland 22, 2010 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): 11 Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be 1 Yes 2 ☐ No Other: မ 1 Nation 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Certificate: 28d. Describe how injury occurred ☐ Natural 5 Pending 2 Accident NOV 18 2010 0725 M 1 Tes 91 Investigation Could not be after deat 3 Suicide 28f. Location (Street and Number Town State) 301 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined arlyon 24 hours Salt hois Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check To the Ivithin 2. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 00062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MaleCular Dr. Rockville, MD 20850 BH 32. Registrar's Signature State

Registrar

0011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 846 5010 NOV Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Mon ockur Omers Casel 0050 8. Date of Birth (Month, Day, Year) DEC5, 1915 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State of Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Min. WASH. 1 M 2 XF Months Days Hours D.C. Director 94 579-05-0544 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County Director 1 Yes 2 I No MONTGOMERY POTOMAC MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral U.S.A. 10718 POTOMAC TENNIS LA. 20854 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 🛛 No 1 Never Married 2 Married by 21215-0036 ☐ Yes 2 X No Specify: Yes, Give WHITE 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) HOME HOUSEWIFE Be 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) GRACE CHAMBERS KATHARINE RUSSELL HARDY MAURICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DAUGHTER 17321 MOSS SIDE LA., OLNEY, 20832 LESLIE MORGAN CHRISTIANSEN, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 11-17-2010 RIVERDALE, MD CHAMBERS CREMATORY 4 Donation 5 Other (Specify) Name and Address of Facility
AMBERS FUNERAL HOME
01 CLEVELAND AVE., . Signature of Funeral Service Licensee E & CREMATORIUM,P.A. RIVERDALE, MD. 20737 WWW M00091 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) 16 Medical Examiner S Sequentially list conditions mo Om if any, hading to immedicause. Enter Underlying Cause (Disease or iinjury as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial-i Physician/Medical Ć Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) PICE 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28a. Date of injury (Month, Day, 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred Certificate: work? 1 🔲 Natural 5 Pending Fe// 2/No 2 Accident 5010 within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu NOY Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office And building, etc. (Specify)

ASS 19 8 / // V/ m3 Fac. 28f. Location (Street and Number or Rural Poute Number, City or Town, State) ל לל לל (City or Town, State) determined opmac mD Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 7/2009

State Registrar 29a, Certifier

(Check

only one) 29b. Signature and title of certifie

COLEMAN,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

M.D.

1355 PICCARD DR., ROCKVILLE, MD.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D37142

NOV. 15, 2010

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

	1	For State Registrar	State of Mar	ryland		irtment of H <i>tificate of D</i>		nd Mental H	gien/ Reg. N	711111	38782
Physician	/	Decedent's Name (First, Middle, Last Varde			M	cPhatter		2. Date of D Month Novem	eath		3. Time of Death 10:52 a M
Medica Examine		4a. Facility Name (if not institution, give s		<u> </u>	IVI	4b. City, Town, or I	Location of D			Ic. County of Deat	
<i>,</i> }	ı	12401 Loft 1				Silv	ier Spi				itgomery
Funeral Director	L	5. Social Security Number 241-50-9442 Usual Residence of Decedent	x XIM2□F	In yrs. Iasi 74	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B Min. (Month, E March	rth ay Year,	9. Bir 936 Nov	thplace (State or Foreign thrity) th Carolina
permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Unportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	- 1-	10a. State 10b. County Maryland Montgo		10c. City,	Town or Loc		Puga	Spring			10d. Inside City Limits
or 28	5	10e. Street and Number	mercy			10f. Zip Code	wei.	Spiring	10g. (Citizen of What Co	<u> </u>
s 23a nust b	<u>ק</u>	12401 Loft 1	Lane				20904			и.	S.A.
ter death , or item miner n	ב ב	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 \(\sum \) Yes 2 \(\overline{X}\) No		13. V	las Decedent of His Yes, specify Cuban	panic Origin' , Mexican, P	? (Specify Yes or No uerto Rican, etc.)	-	14. Race - Ame Black, White	
rs afte		3 Widowed 4 X Divorced	If Yes, Give Year or Dates.	0	1	☐ Yes 2 🛭 No	Specify:			Specify:	Black
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and 2 Healt tem 2	1	Kevin Bryant McPho 20a. Method of Disposition	<u> </u>	_		ition (Name of	ine, S	ilver Spr	T	Location - City or	
Page 1 nent of int: If i		1 ☐ Burial 2 🗶 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,				atory or other place In Cremat		1/18/2010		•	
permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License			22.	Name and Address	of Facility	Hines-Rin	aldi	. Funeral	Home, Inc.
	+	23a. Part 1. Enter the disease, or compl	lications that caused th							ver Spri	Approximate
Physician/		shock, or heart failure. List only on Immediate Cause (Final disease or condition	Arrhyth	hmia							Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as a c			Eailura					
الله الله الله الله الله الله الله الله		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequer	nce of):	Failure					
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or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi. Certificate: To Be Completed by Physician/Medical Exam		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal c	death 3 🗌	Ectopic pregnancy Other (specify)				23d. Date of del Month	ivery Day Year
that the ned by detac		Part II. Other significant conditions con	ntributing to death but	not result	ing in the ur	nderlying cause give	n in Part I.	23e. Did	tobaccc	use contribute to	the cause of death?
v requires that it is been signed by should be detailed by Poleculary Polecul		Diabetes, Hyperte	ension, Epi	ileps	y, Ca	rdiomyopa	thy,	_ 1 🗆	Yes :	2 X No 3 □ Pr	robably 4 🗌 Unknown
The law requires tha rate has been signed page 2 should be de		Atrial Fibrillate	ion, Hyperc	chole	stero	lemia, St	roke,	24a. Was	psy	prior to d	opsy findings available completion of cause of
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hysician his certifi I director		evaminer?	łospital: 1 ☐ Inpatient	۰ ۵ 🗆 ۲۰	7/O-+	Other		Check only one)		a 🗆 au - a	
g Phys ter this neral dir		27. Manner of Death	28a. Date of injury (Month, Day, Y	28	Bb. Time of injury	28c. Injury a	at	ng Home 5 🗶 Res 28d. Describe			TY)
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al or Attending P s after death. Director: After t d in by the funeral Certificate:		4 Homicide determined	28e. Place of Injury building, etc. (\$		e, farm, stre	et, factory, office		28f. Location City or To		nd Number or Rur e)	al Route Number,
To the Hospital or Attending Within 24 hours after death. To the Funeral Director: Afte completed filled in by the fun Medical Certificat	Polinola	(Check 2 Medical Examin	ician: To the best of my er: On the basis of exame Practioner: To the best	mination a	nd/or investi	gation, in my opinion	, death occur	rred at the time, date	and plac	ce, and due to the c	ause(s) and manner stated
To t Som	12	29b. Signature and title of certifier	/ 1			29c. License r	number		29d. D	ate signed (Month	, Day, Year)
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	ľ	30. Name and address of person who co Robert Webster Ti					ut Av	enue. Ken	sina	ton. MD	20895
State	3	31. Date filed (Month, Day, Year) 18 2010	2. Registrar's							,	
Registrar		MAN TO SOM	Believe	A.	gar						

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:20a M November 12, Harry N. Maragides 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Randolph Hills Nursing Home Wheaton Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1**** M 2□F Days Months Hours Yrs. 348-16-8264 85 June 09.1925 Illinois Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Counts r then "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🛛 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11006 Veirs Mill Road, #L15-216 20902 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: WW I I 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ™ Widowed 4 □ Divorced White WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) e filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Professor Education 5+ Permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other traumatic avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nicandros Maragides Efrosyne Theodosis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3142 Hewitt Ave., #134. Silver Spring. MD 20906 Mark A. Maragides - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Pk. 11/19/2010 Rockville, Maryland `4 Donation 5 Other (Specify) 21. Signet, re Fureral Service Licens e 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M012 11800 New Hampshire Ave., Silver Spring, MD 20904 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Sepsis Syndrome /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physicien and defeated for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Alzheimer's Disease 1 Yes 2 No 3 Probably 4 ∑Unknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 1 Yes 2 X No tel or Attending Physicien: T is after death. el Director: After this certificat Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 🛛 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 🕱 No ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 (X) Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funerel L 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 D52261 November 12, 2010 DAG Greet / 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Segal. M.D. 1517 Hugo Circle, Silver Spring, Maryland 20906 31. Date filed (Month, Day, Year) 3. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

NOV 18 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 11/15/2010 MICHAEL A. MESSURI 8:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Center Towson If Under 1 Year Social Security Number 6. Sex 1 ፟፟፟X M 2 ☐ If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY . Age (In vrs. last birthday 8. Date of Birth **Funeral** Days 05/30/195 Director 109-42-3101 59 Usual Residence of Decedent or 28a-f shov notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No MD Baltimore Reisterstown 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 200 Erin Way, #104 21136 USA an "natural", or items. Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. δ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <u>Photographer</u> Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Messuri Felicia Cetkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony J. Messuri - son 9338 Cherry Hill Road, #204, College Park, MD 20740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery) crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from Stat Ardent fremation Svc: 11/17/10 4 Donation 5 Other (Specify) Hanover, MD 21. Signatur of Juneral Service License 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease or complication shock, or heart failure. List only one can o not enter the mode of dying, such as cardiac or respiratory arrest, is that caused the dea Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjur) been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Year Pregnant at time of death 1 Yes 2L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \text{Nother (Specify)} မှ 1 🗌 Yes 2X No HOSDICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XX Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation within 24 hours after deatl To the Funeral Director: the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifie 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Cettiving Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and the cause(s) and manner stated the time, date and place, and the cause(s) and manner stated the time. only o 29b. Signat nd title of dertifier P 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (N

onth, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rosaura Medina 6:30 AM November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Olney Hospita Montgomery Mentgomery (Teneral If Under 1 Year If Under 24 Hrs. 8. Date of Birth Feb. 21 Year 935 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🔀 F Days Min. Hours Months Efountal vador 212-63-1054 75 Yrs Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location
Brookeville 10a. State 10b. Count r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director MD Montgomery 1 Yes 2 No 10f. Zip Code 20833 10e. Street and Number 10g. Citizen of What Country? El Salvador 19721 Olney Mill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖾 No Black White etc. ð 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 El Salvadoran White If Yes, Give Specify. Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Dccupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other t any injury or other traumatic event, the once. Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia Medina Dionicio Trejo ည 19a. Informant's Name/Relationship (Type, Print)
Isabel Portillo/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19721 Olney Mill Road Brookeville, Md 20833 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other pla ²⁰Sesori, San Miguel, 0 El Salvador 1 Burial 2 Cremation 3 Removal from State Municipal Cemetery 11/24/201 0 4 ☐ Donation 15 ☐ Other (Specify) n ral Service Lic Signature lot PHYMETPADESRINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Introcranial hemorrhage Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a d be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown as been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N certificate ha 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 **X**No Other: 1 Yes မ 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of o the Hospital or Attending Plithin 24 hours after death.
o the Funeral Director: After the ompleted filled in by the funera 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending М 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2
To the complex only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Bichhum 754996 3 M November 9010 16 Dinh Bichhuong M.D.

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.0.

Records,

Olney

, MD

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phili

Prince

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra MEND#8penFH, 11/18/10, BWW, MbCo Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 1^{2} , 2010Mannarino November 7:45 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number 5630 Wisconsin Avenue #1104 Montgomery Chevy Chase 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth 1931 1 🗆 M 2 💢 F Months Days Hours Min. Nov 23, Year 10 577-56-3382 Germany Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County Chevy Chase 1 X Yes 2 No Montgomery 10f. Zip Code 20815 10g. Citizen of What Country? 10e. Street and Number 5630 Wisconsin Avenue #1104 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify. White 3
Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Physician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maria Straube Friedrich Wunderlich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5630 Wisconsin Ave #1104 Chevy Chase, MD 20815 Emanuele Mannarino/Husband 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Silver Spring, MD Gate of Heaven Cem! 11-17-2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Acute Congestive Heart Failure 3 Days resulting in death) Due to (or as a consequence of): 2 Years Multiple Metastases Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dusite (or as a consequence of): 2 Years Bilateral Breast Cancer Recurrance that initiated events resulting in death) Last Due to (or as a consequence of) 13 Years Breast Cancer

Physician Medical Examiner

> and as the burial-trar

attending physician

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certificate has been signed by the atte irector, page 2 should be detached for

To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di

12

executed

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Physician/

Medical

Director

Funeral

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Completed

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MD

Examiner

Funeral

Director

should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036 Carlot Page 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin

Examine Physician/Medical 2 Completed BB ္ဝ

Certificate: Medical

IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month in the past 12 months?
1 Yes 2 No Pregnant at time of death g Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 XNo prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical	26. Place of Death (Chec	26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 Ž No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing He	ome 5 🕱 Residence 6 🗆 Other (Specify)							
27. Manner of Death 1 ▼Natural 5 □ Pending 2 □ Accident Investigation	(Month, Day, Year) injury work?	28d. Describe how injury occurred							
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)							

29a	. Certifier	1 X Certifying F	Physician: To	the best of	f my knowled	ge, death occui	red at the time, date and place, and due to the	cause(s) and manner as stated.
	(Check	2 Medical Ex	aminer: On the	he basis of	examination ar	nd/or investigation	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner state
	only one)	3 Certifying N	Nurse Practi	oner: To the	e best of my kr	owledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated.
2016		d title of certified	- //	11	- //	/	29c. License number	29d. Date signed (Month, Day, Year)

D02338

11/15/2010

30. Name and address of person who completed cause of death (kem 23a) (Type, Print)

1 8 2010

Richard P. Delaney MD 3929 Ferrara Drive Wheaton, MD 20906

State Registrar 31. Date filed (Month

egistrar's Şignatı

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Year George F. McAulay 1540 2010 Medical Nov 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital Shady Grove Adventist Rockville Montgomery If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Wash., DC 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** (Month, Day Ye 1 🗙 M 2 🗆 F Months Hours Min Director 64 217-44-2561 Jan. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show th∗ Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg MD Montgomery 1 X Yes 2 ☐ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 30 O'Neill Drive #1 20877 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status med Forces?

X Yes 2 □ No
Yes, Give 14. Race - American Indian, UKN Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Government Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of John Henry McAulay Mildred E. Bankerd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Adelphi, MD 20783 permit. Page 1 and 2 shr Department of Health an Important: If item 27 is <u>Jean McAulay/Sister</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Howard University Medical School any injury or ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 11/8/10 Washington, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, NW, Washington, DC 20011 M00969 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner intection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami ending physician and use as the burial-transit osteo arthritis that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dehudration Completed 1 Yes 2 No 3 Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ၉ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, nin 24 hours after death.

the Funeral Director: After thi

ppleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Division ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check hin 2 2 29b. Signature and title of certifier 29c. License number 59013 November 6, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shady Grove Rd. #140 Rockville, Mary land 2050 KHLUDENEV. MD 15825

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (A

Box 68760

P.O.

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2. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First Middle Last) 3. Time of Death Day Physician/ Month Felix G. Mazumder 645 9 M 20010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1806 Metzerott Road, #305 Hyattsville P.G. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sept 1, 1940 Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 D F Min. Hours 70 Bangladesh 220-83-7317 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Tes 2 No MD P.G. Hyattsville 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 1806 Metzerott Road, 20783 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Yes 2 No Yes, Give Completed by Beltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Asian "natural" 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be f Louis G. Mazumder Magdelena Anjus and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh ment of Health a tant: If item 27 is Euphraise Mazumder/Wife 1806 Metzerott Rd., #305, Hyattsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Nov. 20 Gate of Heaven 1 X Burial 2 Cremation 3 Removal from State Silver Spring, ΜD 4 ☐ Donation 5 ☐ Other (Specify) 2010 emetery 21. Signature of Funeral S wice Licenses 27 Yarne and Address of Facilities Inc. Hites 500 University Blvd. W., Silver Spring, MI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Verotic Cartovacan ATRENOSC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a nonsequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 🗌 Yes 2 1 To the Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify, 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300, 32: Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene > 1 1 - State Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Maroulis 8:53 a M Angelos John Nov 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 11503 Taber Street Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Greece 1 🖾 M 2 🗆 F Months Days Hours Feb 10, Year) 1923 579-42-8676 87 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City. Town or Location Director notified 1 Yes 2 X No MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 6 10e. Street and Number must be 23a Funeral with 11503 Taber Street 20902 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 5 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after SpecifyWhite If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 Chef Restaurant Be 18. Mother's Name (First, Middle, Maiden Surname) filed 17. Father's Name (First, Middle, Last) of Health and Mental Forters of Health and Mental Forters of them 27 is marked or other traumatic eve မ John Maroulis Akrivi Vlasopoulos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health an Important: If item 27 is m any injury or other. 19a. Informant's Name/Relationship (Type, Print) 20902 11503 Taber St., Silver Spring, MD Georgia Maroulis/Wife Date 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Gate of Heaven Nov. 2 2010 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Silver Spring, 4 ☐ Donation 5 ☐ Other (Specify) emetery 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. Spring, MD 500 University Blvd. W., Silver 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Multiple Myeloma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Severe Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and I-transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2√No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes cate has been signated bage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hospital or Attending Physician: The 24 hours after death.
Funeral Director: After this certificate I eated filled in by the funeral director, page 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D27660

State Registrar 30. Name and address of pe

Alpana

31. Date filed (Month

rson who comp

2010

Go'swami,

MD

11125 Rockville Pike,

20852

MD

#110, Rockville,

ed cause of death (Item 23a) (Type, Print)

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

)	3	8	7	9	

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** November \mathbf{P}^{M} Bernice Teunis Mann 17 2010 7:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Healthcare Center Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Sept. 28 1905 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Michigan 385-22-4593 Sept. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State er than "natural", or items 23a or 28a-f show 1 Yes 2 □ No Director DC Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5403 Nebraska Avenue, N.W. 20015 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: <u>ک</u> Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If item 27 is marked other the any injury or other traumatic event, the once. Secretary Federal Reserve Board 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roelf Teunis Catharina Bowman ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia J. Miller/Daughter 18750 Cross Country Lane, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Metropolitan Crem. 11/18/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 22. Name and Address of Facility 21. Signature of Funeral Service Vicensee Devol Funeral Home M00689 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part I. Etter tije disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Donset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical mente carlierasculas desease **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Division or vical incomplete that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be executed to the Hospital or Attending Physician and Theorem Physician and Theorem Physician a Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown renaldes 24a. Was an Were autopsy findings available prior to completion of cause of performed? Yes 2 MNo death? Recurrent greumom 1 □Yes 1 TYes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04115 14 Dexect De 201 RUSSEL AVENUE 641THERSBURG MAS 30. Name and address of person who completed cause of death (Item 3a) (Type, Print) H. ROBERT BIRSCHBARGH MLA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Registrar 2, Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Mattingly Therese Marv Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Allegany Cumberland WMHS-RMC 9. Birthplace (State or Foreign Country) MD_ 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day Ye 1 🗆 M 2 🗆 🗜 Months Hours 1925 Director 216-22-7344 85 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director filed within 72 hours after death with the Maryland Cumberland Examiner must be notified 28a-f MD Allegany 1 □X/es 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 23a Funeral 21502 USA 515 Greenway Avenue items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married "natural", or þ 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify. white 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) Callege (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, permit. Page 1 and 2 should be file
Department of Health and Mental I.
Important if item 27 is marked of
any injury or other traumatic and Mental F ဂ္ Angela (Carpenter) Neely Joseph Robert Neely 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
53 Greene Street Cumberland MC 19a. Informant's Name/Relationship (Type, Print) MD 21502 Edward Mattingly Jr. Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
SS Peter Paul Cemetery 1 🗵 Burial 2 🗌 Cremation 3 🔲 Removal from State 11/24/2010 MD Cumberland 4 Domation 5 Other (Specify) 21. Synature of Funeral Synice Licensee 22. Name and Address of Facility
Scarbelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NIPL Physician/ 5 /2 mente disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a surranguer se ut) if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed ronan 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20 use of death (Item 23a) (Type, Print) 30. Name and address of person who completed ga 5 MA nRS egistrar's Signatur Date filed (Mont) State 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Funeral Director 5. Social Security Number 215-34-7465 Usual Residence of Decedent 10a. State 10b. County MD Montgomery 10c. City, Town or Location Silver Spring 10c. City or Code	Year 3. Time of Death 3:45 A M of Death GOMETY 9. Birthplace (State or Foreign Country) VA
Physician/ Medical Examiner DORIS MAE MOTEN 4a. Facility Name (if not institution, give street and number) Fox Chapel Nursing Home Funeral Director Director DORIS MAE MOTEN 4b. City, Town, or Location of Death Fox Chapel Nursing Home Silver Spring Montto 4c. County of Montto 1	Year 3:45 A M of Death GOMETY 9. Birthplace (State or Foreign Country)
Funeral Director 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Silver Spring Monto 4c. County of Silver Spring Monto 5. Social Security Number 6. Sex 1 Months Days Hours Min. (Month, Day, Year) 06/21/1937	of Death JOMERY 9. Birthplace (State or Foreign Country)
Fox Chapel Nursing Home Funeral Director Fox Chapel Nursing Home 6. Sex 1. Age (In yrs. last birthday) 1. Age (In yrs. la	9. Birthplace (State or Foreign Country)
Funeral Director 5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) 1. M 2 XF 7. Age (In yrs. last birthday) 1. Months Days Hours Min. (Month, Day, Year) 06/21/1937	Birthplace (State or Foreign Country)
Director 215-34-7465 1 M 2 XF 73 Yrs. Months Days Hours Min. (Month, Day, Year) 06/21/1937	
House Pagidanae of Decedons	
MD Montgomery Silver Spring 100. Street and Number	140.11.11.00.11.11
Note of the street and Number Silver Spring	10d. Inside City Limits 1 ☐ Yes 2 🔀 No
製	That Country?
8510 16th Street, #201 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race	- American Indian,
Armed Forces? Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black The state of the st	k, White, etc.
3 Widowed 4 Divorced If Yes, Give 1 Yes 2 No Specify: Specify:	Black
Specify: Specify:	siness Industry
Elementary/Seconday (0-12) College (1-4 or 5+) iffe. DO NOT use retired) Pharmacy Clerk Giant Fo	boo
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
Robert Moten Mary Newman	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta	ate, Zip Code)
Chicquita Moten - daughter 8510 16th Street, #201, Silver Spring	, MD 20910
20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 X Cremation 3 Removal from State cemeter, crematory or other place) 20c. Location - (City or Town, State
A Donation 5 Other (Specify) Mrdent Cremation Svc 11/29/10 Hanover	<u> </u>
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Ho	
246 N. Washington St, Rockville, i	
shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
disease or condition Modical resulting in death) a. a. a. a. a. a. a. a. a. a. a. a. a. a	6 months
Examiner Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
cause. Enter Underlying Cause (Disease or linjury tresulting in death) Last Cause (Disease or linjury tresulting in death) Last C. Due to (or as a consequence of):	
W IF FEMALE: 23c. If yes, outcome of pregnancy	
FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date 23d.	e of delivery hth Day Year
g Unknown g Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	bute to the cause of death?
y 50 0 HTN 1 Yes 2 No 3	3 ☐ Probably 4 💆 Unknown
TIN 1 Yes 2 No 3 24a. Was an 24b. Was an 34b. Wa	/ere autopsy findings available
autopsy pr performed? de	rior to completion of cause of eath? Yes 2 X No
25. Was case referred to medical examiner?	
Pospital: Hospital: Hospital: Hospital: Hospital: Hospital:	(Specify)
28a. Date of injury 28b. Time of injury at work?	t
ຂໍສິ່ງ 2 ☐ Accident Investigation M 1 ☐ Yes 2 ☐ No	and Devel Developher
3 Suicide 6 Could not be	or nural noute Number,
28a. Date of injury 28b. Time of injury 28c. Injury at work? 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number City or Town, State)	
The standard of the standard o	r as stated.
3 Suicide 3 Suicide 4 Homicide 5 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Xeertifying Nurse Practioner: To the best of my knowledge, death occu	to the cause(s) and manner stated.
29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner (Check onl	to the cause(s) and manner stated.
2 R169951 11/19/1	to the cause(s) and manner stated. nner as stated. (Month, Day, Year)
R169951 11/19/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	to the cause(s) and manner stated. nner as stated. (Month, Day, Year)
2 R169951 11/19/1	to the cause(s) and manner stated. nner as stated. (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year NIKOLAUS **Physician** 2122 M TRICIA 2016 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arunde Annapolis r 1 Year | If Under 24 Hrs. Anne Arundel Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** Months Days Hours Min. 1 □ M 2 □ F Yrs. Aug 10, 1940 Wisconsin 70 396-38-3506 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 3a or 28a-f show 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Anne Arundel Crofton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21114 United States 1754 Woodridge Court 7 is marked other than "natural", or items 23a traumatic event, the Medical Examinar must t Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Eyelyn Hielsberg Harvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1754 Woodridge Court Crofton, Maryland 21114 David R. Nikolaus/husband permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/20/10 Woodbine, Maryland 21. Sign were of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Homas Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Partit Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DAYS **Physician** 515 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner NEUMUN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2
Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital After this certification, I 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1☐Inpatient 2☐ ER/Outpatient 3☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Hospital

D

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

W IEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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σ.	that ined by detail		Part II. Other signi	ficant conditio	ns contributing to death	but not res	ulting in the	e underlying cau	se given i	in Part I.	2	3e. Did to	bacco use conti	ibute to th	ne cause of deat	h?
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific Within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as a completely filled in by the funeral director, page 2 should be detached for use as formal and the funeral director.	ed by									_ []	1 □ Y	es 2□No	3∏ Prob	ably 4 Unki	nown
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	he Ho in 24 he Fu pletel	Medical	(Check only one)	2 Medical E	xamîner: On the basis epa manner	of examina stated.	ation and/o	r investigation, ir	n my opin	ion, death	occurred at	the time, o	date and place,	and due to	the cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Raymond J. Nowicki, Sr. 2010 1:40 a.M Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 📈 M 2 🗆 F Months Country Director 217-05-7374 90 0/6/1920 M Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No MD Carroll Westminster 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 225 Frock Drive, Apt. 259 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give WWII
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", 3 XWidowed 4 Divorced Specify: white Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Foreman Armco Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Michael Nowicki Cecelia Winiecki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond J. Nowicki, Jr., son 294 Winterberry Lane, Westminster, Md. 21157 27 permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cem. 11/10/2010 Baltimore, Md. 22. Name and Address of Facility Eline Funeral Home Signature of Funeral Service Licensee M00741 Main Street, Hampstead, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ARDS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 2 days SEDSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p for use as t IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHF Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has completed filled in by the funeral director, page 2 performed? Yes 2 No To the Hospital or Attending Physician: The certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 X No 1 Yes ျ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Theresa 00047979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Westminster, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 12 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14711/2010 Yea ERNEST LAWRENCE ONLEY 1600 M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Hospital Rockville Montgomery Social Security Number 6. Sex 1 X M 2 □ F If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Months Hours 12/31/1929 Director 214-28-4706 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Montgomery Dickerson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21120 Beallsville Road 20842 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: Completed Year or Dates Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpentry City of Rockville Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Onley Octavia Ambush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Onley - wife 21120 Beallsville Road, Dickerson, MD 20842 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from St Ardent Cremation Svc: 11/19/10 4 Donation 5 D Other (Specify) Hanover, MD 21. Signature of heral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 Part 1. Enter the disea at, or complishock, or heart failure. List only or ions that caused the dear. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia Physician/ disease or condition resulting in death) Medical le to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) attending physician and for use as the burial-trensit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown this certificate has been signed by the arral director, page 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ence phalopath, 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown failure acute 24b. Were autopsy findings available prior to completion of cause of death? rena 24a. Was an performed' parkinson's dementa 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🔀 No 1 Tes မြ 1 Nation 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 1 🔼 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kane MD NOVEMBER, 11th, 2010 1068178 ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rodwille, Santos r . 31. Date filed (Month, Day, Year) Rane, 20850 MP 9901 Medical State 2. Registrar's Signature Registrar

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shou and N s mai		19a. Informant's Na	ame/Relationship (ng Address (Stre	et a <i>nd Nun</i>	nber or Rura	al Route Num	ber, City	or Town, State, Zip	Code)
and 2 ealth n 27 i		David 0	Bryon -	Son				iery L				Maryland	
Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Medical Examination in cliffed at		20a. Method of Disp 1 ☐ Burial 2		Removal from State	Ce	emetery, cre	osition (Name of matory or other p			Date		ocation - City or To	,
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (29a. Certifier (Check only one)	1 X Certifying Pi 2 ☐ Medical Exa	hysician: To the bes miner: On the basis and manner s	of examina	wledge, dea tion and/or i	th occurred at the nvestigation, in m	e time, date y opinion, d	and place, death occur	and due to the red at the tim	ne cause(e, date an	s) and manner as nd place, and due t	stated. to the cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State		State of M	larylan		artmen <i>tificate</i>			and M	1ental Hy	_	201	n	38799
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οι	Attending Physician: or death. ector: After this certific by the funeral director,	ate:		5 Pending	28a. Date of injui (Month, Day	ry , Year)	28b. Time of injury	- 1	c. Injury at work?	t	2	8d. Describe h				
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	vithin 2 o the i	ĭ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											ted.		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 15, Day 2010 ear Physician/ Nov. 6:50 p M Pham Duven Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Yea 1 🗌 M 2 🕱 Director 7 7Yrs 612-23-9225 933 Vietnam Aug. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d Inside City Limits 10c. City. Town or Location Director 1 ☐ Yes 2 K No Silver Spring MD Montgomery 10e. Street and Number 10g. Citizen of What Country? 2859 School House Circle 20902 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian 1 Yes 2 X No Completed 3★ Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dinh Pham Dieu Pham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6330 Skywalker Dr.,. San Jose, CA 95135 Henry Nguyen/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Nov. 18 1 ☐ Burial ※ Cremation 3 ☐ Removal from State Metropolitan Crematory 2010 Alexandria, VA 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Frameriador of Facilitations Funeral Home 500 University Blvd. W., Silver Spring, Mt 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition Colon Cancer months Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-trunsit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death signed by the a d be detached f 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy certificate | 2 X No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🖾 No Other: ၉ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury

within 24 hours after death. To the Funeral Director: After this

work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State, Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier 29d. Date signed (Month. Day. Year. D 0065485 RSM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1500 Supanich, RSM MD Forest Glen Road, Silver Spring, MD

State Registrar

31. Date filed (Month, Day, Year) 32 Registrar's Signature MOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3880 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:00am Dorothy Clara Poole November 13. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Asbury Methodist Village Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Yrs. **Director** May 03. 097-16-9498 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Mental Experiment of Once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🛛 No Director Gaithersburg Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 407 Russell Avenue, Apt. 714 20877 u.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 🛛 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 🛛 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank W. Sepure ဂ Maria Arnold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 Russell Ave., Daniel A. Poole - Spouse #714. Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 11/19/2010 | Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Funeral & Cremation 21. Signature of Funeral Service Licensee HO#1070 LCtr. 1040 Rockville Pike, Rockville<u>, MD 20852</u> 23a, Part 1. Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Court Final disease or condition resulting in death) Physician 400 /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dire to for as a nonsequence off or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 No-24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ∐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1∐Yes 2<mark>17</mark>1No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending ours after death.

neral Director; A
filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital Agrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29b. Signature and title of certifier 29c. License number d address of person wh completed cause of death (Item 20a) (Type, Print) Murice 911

Registrar DHMH 17 Rev 1/2001

State

John 31. Date filed (Month, Day, Year)

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ November 19, 2010 Year 4:22 A Nevin Foster Price Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville 14211 Chesterfield Road Social Security Number 8. Date of Birth (Month, Day, Year Oct. 9, 1924 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) Months 1 **№** M 2 🗆 F Days Hours Director 191-14-9807 86 Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director 1 ☐ Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20853 USA 14211 Chesterfield Road 12. Was Decedent Ever in U.S. Armed Forces? 1943–45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes. Give 1951-54 Specify: 3 Wildowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer's Rep Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles J. Price Eliza C. Mikels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9387 Wintercreek Court, Tallahassee, FL 32309 Cynthia Jo Smith/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 🔀 Cremation 3 D Removal from State Nov. 19 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 2010 21. Signature of Funeral Service Licensee Name and Address of Facility Fancis J. Collins Funeral Home Inc 500 University Blvd. W., Silver Spring, MD 20901 Michard L. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pancytopenia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 10 yrs Myelodysplasia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant a 9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 No s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 🗶 Natural

Division of Vital Records, P.O. Box 68760

within 24 ho

To the Fune To the

24 hours after death. Funeral Director; A

filled in by the

Medical

Accident

3

29b. Signature and title of cer

31. Date filed (Month, Day, Year,

3 ☐ Suicide 4 ☐ Homicide Suicide

29a. Certifier

(Check

only one)

Investigation

determined

6 Could not be

State Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0066990

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

who completed cause of death (Item 23a) (Type, Print) MD 6420 Rockledge Road, Bethesda, MD 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State of Ma		artment of Healti <i>tificate of Deatl</i>	h and Mental Hyg h	Reg. No.	38803
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Robert Lee Phipps			2. Date of Dea Month	th Day Year	3. Time of Death 0 12:30 a M
	Medic Examin	al .	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		4c. County of Deat	h
يميع .			Long View Nursing Home 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Mancheste	der 24 Hrs. 8. Date of Birti	Carro	thplace (State or Foreign
	Funeral Director		213–20–1762 1 MM 2 🗆 F	85 Yrs.	Months Days Hour		(1 ^{Year)} 1925 Wes	t Virginia
	and show at	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc				10d. Inside City Limits
	Maryla 28a-f	irect	Maryland Carroll			minster	10-000	1 X Yes 2 □ No
	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 212 Pennsylvania Avenue		10f. Zip Code	21157	10g. Citizen of What Co USA	
	r items		11. Marital Status 12. Was Decedent E Armed Forces? 1 Never Married 2 Married 1 Yes 2	. If	Vas Decedent of Hispanic f Yes, specify Cuban, Mexi	Origin? (Specify Yes or No- ican, Puerto Rican, etc.)	14. Race - Ame Black, White	
9036	ırs after ural", o I Exam	ted by	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates.	WWII 1	☐ Yes 2 X No Spec	cify:	Specify: W	hite
15-(72 hou in "nati Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5	most of working	16b. Kind of Business			
212	d within ygiene. her tha nt, the I	as I	2	<u>M</u>	achinist	The state of the s	Manufac	turing
land	be filed lental H rked ot ic ever	To B	17. Father's Name (First, Middle, Last) Walter Phipps			Nother's Name (First, Middle, Crise McMilla		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ı	19a. Informant's Name/Relationship (Type, Print) Gail Jones – guardian	19b. Mailin 125	ng Address (Street and Nur Stoner Ave	mber or Rural Route Number e. Westmins	r, City or Town, State, Zij ter, MD	21157
Baltimore,	e 1 and t of Hea If item or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place of Dispo- cemetery, crem	natory or other place)	Date	20c. Location - City or	
Itim	nit. Pag artment ortant: injury e		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Cemetery 1 Name and Address of Fa	1 1/16/2010	Ashe Co., boraw Funer	
Ba	permit Depar Impor any in	. 8	Justa R. Duebor	2	91 Willis St	reet, Westmir	ster, MD 2	1157
l,			23a. Part J. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final		er the mode of dying, such	n as cardiac or respiratory an	rest,	Approximate Interval Between Onset and Death
	Pnysician Medical Examiner		disease or condition resulting in death) a	a consequence of :	1)			5 days
	Ladininei	Jer	Sequentially list conditions, if any leading to immediate b. Due to or as	a consequence of):	(L)		50	20 Mile
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events c	200000000000000000000000000000000000000				
0	icate be executed physician and s the burial-transit	edical E	resulting in death) Last Due to (or as	a consequence of):				
876	tificate ng phy	Medi	IF FEMALE:					
Box 68760	for the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transity → N√7∠.	by Physician/M	23b. Was decedent pregnant 23c. If yes, outcome	2 Fetal death 3 E	Ectopic pregnancy Other (specify)		23d. Date of de Month	blivery Day Year
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Division of Vital Records, P.O.	The law require te has been si bage 2 should l	Completed				24a. Was autoj perfc 1 □ Yes	psy prior to death?	utopsy findings available completion of cause of successions 2 \sum No
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of V	ig Phys ter this neral di	te: To	27. Manner of Death 1 Inpat 28a. Date of injute (Month, Date of Injute (Month, Date of Injute (Month), Date of Injute (Month		f 28c. Injury at work?		now injury occurred	ону)
sion	vttendir death. ctor: Af y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ury - At home, farm, str	M 1 ☐ Yes 2 eet, factory, office		Street and Number or Ru	ural Route Number,
Divi	irs after al Direction by led in by	al Cel	4 🗆 Homiciae determined building, et	c. (Specify)		City or Tov		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 strongles with the funeral director, page 2 strongles with the funeral director, page 2 strongles with the funeral director, page 2 strongles with the funeral director, page 2 strongles with the funeral director, page 2 strongles with the funeral director of the funeral director of the function	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of 6 only one) 3 Certifying Nurse Practioner: To the	vamination and/or inves	tigation, in my opinion, dear	ath occurred at the time, date a	and place, and due to the	cause(s) and manner stated.
	To the Vithin To the Comp	~	29b. Signature and title of certifier	esa DI	29c. License numb		29d. Date signed (Mont	
月	UTIVA		30. Name and address of person why completed cause of c	leath (Hem 23a) (Type, F	Prigt) MINSTER	MD. 5	1157	10
	Sta			ar's Signature	مرا ا	7.10.0	1191	
	Registr	ar	NOV 1 2 2010 Cone	a p. 400	are			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 2:40 A November Ruth Maxine Peterson . Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar 15, 1928 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Pennsylvania Director 82 176-24-8960 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City. Town or Location 10a. State filed within 72 hours after death with the Maryland Director or 28a-f sl 1 Yes 2 No Maryland Derwood Montgomery 10f. Zip Code 10g. Citizen of What Country? ò 10e. Street and Numbe "natural", or items 23a o edical Examiner must be Funeral 20855 United States 17732 Caddy Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Business Machine Co 4 Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 pe Wilda Sparkenbaugh Mae Richard Paul Fierst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 27 Maryland 20855 Norman C. Peterson/husband 17732 Caddy Drive Derwood, item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite 1 Burial 2 X Cremation 3 Removal from State 5 injury o 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 11/18/2010 Woodbine, Maryland nure of Funeral Service Licenses Coing Homes Cremation Service P.O. Box 784 anta Heckrotte, P.A. Clarksville, MD 21029 M00957 Beverly L. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition routes truck Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (of as a consequence of): g physician and as the burial-transit law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical anding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy atter for u in the past 12 months? Dav 5 Other (specify) been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has the performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 No 1 Yes 1 Inpatient 2 ၉ ER/Outpatient 3 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this of funeral din 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. neral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of certifier November 15, 2010 of person who completed cause of death (Item 23a) (Type, Print) Phillip Dr Olney, Maryland 20832 Khmanin

DHMH 17 Rev 7/2009

State

Registrar

Date filed (Month, Day, Year)

32. Registrar's Signature

SELLAN -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11/17/2010 11:55 PM SAMUEL CLINTON POWELL, SR Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring 12115 Dalewood Drive Social Security Number . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MD Country) 1 🛛 M 2 🗆 F Hours 12/29/1942 Director 67 216-40-8424 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1X Yes 2 No Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 20902 12115 Dalewood Drive Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 X Married ð Maryland 21215-0036 1 Yes 2 No If Yes, Give Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Montgomery County and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools Boiler Engineer 10th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Young Edward Craig Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury 12115 Dalewood Drive, Silver Spring, MD 20902 Clara E. Powell - wife Baltimore, f Disposition (Name of N, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Plac 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from 4 ☐ Donarian 5 ☐ Other (Specify) Cremation Svc 11/29/10 Hanover, MD of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 plications that caused the dea Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Enter the dise or co shock, or heart failure. List 6 months Immediate Cause (Final Lung cancer, metastatic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) 司 cause. Enter Underlying e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Funeral Director, After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transities. Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) ☐ Pregnant
☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 Yes 2 X No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA ္ပင 1 🔲 Yes 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the P within 2. 3 E

State

Registrar

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) NOV 23

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D57304

29d. Date signed (Month, Day, Year)

11/18/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 20. Physician/ 2010 3:24 P Elaine Ron Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5600 Lone Oak Drive Bethesda Montgomery 8. Date of Birth (Month, Day, Year) NOV 19, 1943 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days Months New York 1 M 2 X F Hours **Director** 67 091-34-6272 Usual Residence of Decedent show. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Ħ within 72 hours after death with the Maryland Director or 28a-f sh notified Maryland Montgomery Bethesda 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 20814 United States 5600 Lone Oak Drive an "natural", or items Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry the M Elementary/Seconday (0-12) College (1-4 or 5+) filed within all Hygiene. 5+ <u>Epidemiologist</u> Federal Government Be Department of Health and Mental H, Important! If Item 27 is marked oth any injury or other traumatic... 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mark Judith Weinroth Straus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5600 Lone Oak Drive Bethesda, Maryland 20814 Ariel Ron/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cernetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State inal Journey Crematory 11/24/2010 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Sign twee of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD Lande Thomas M00957 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Amoullary Carcinoma 3 months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of) physician and the burial-transit executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Year Month Day 5 Other (specify) 2 X No ed by the a g Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed 1 ☐ Yes 2 ☐ No After this certificate funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home \(5\mathbb{X}\) Residence \(6\sum \) Other (Specify) 2 X No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 X Natural 5 Pending 1 Yes 2 🗌 No thin 24 hours after death. the Funeral Director; Al mpleted filled in by the fu death. Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D43083 November 22, 2010

State

Registrar

15

egistrar's Signature

9707 Medical Center Drive, Suite 300 Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sotos, M.D.

3

George A.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Richard November 1:00 Rappaport Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 10720 Autumn Splendor Drive Columbia Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral 1 🖳 M 2 🗆 F Months Days Hours 043-24-3544 80 374/1930 **Director** Usual Residence of Decedent items 23a or 28a-f show ier must be notified at 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MdHoward Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Autumn Splendor Drive 21044 USA 10720 12. Was Decedent Ever in U.S.
Armed Forces?
1 ♣ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced Completed White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Army Corps Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Reuben Rappaport Evelyn Yusko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Ross Rappaport - Son 6107 Hour Hand Ct. Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it
any injury or o
once. ₽ cemetery, crematory or other place)
Ardent Cremation 1 Burial 2 X Cremation 3 Removal from State 11/23/10 4 Donation 5 Other (Specify) Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Ind neral Service Lice Det M01411 4112 Old Columbia Pike Ellicott City, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CONGESTIVE HEART disease or condition 6 Montre Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attendion abusiness. ng physician and as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day Pregnant at time of death should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 page 2 2 🗌 No 1 Yes Division of Vital completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 **N**o Hospital: Other: 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 stifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tile of certifier

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31. Date filed (Month Registrar

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rson who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar MD, TCHD, 11/18/10, r1s Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2:45 **P** M CARL BROWN REED 11 14 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CANDLE LIGHT COVE TALBOT **EASTON** If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 □ F 85 Yrs 06/20/1925 219-14-8365 MD Director Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10a State 10c. City, Town or Location show r than "natural", or items 23a or 28a-f sho 1 Yes 2 □ No Director MD TALBOT EASTON 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral 700 PORT STREET #102 21601 UNITED STATES 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 X Yes 2 No 1943− If Yes, Give Year or Dates: 1946 1 Never Married 2X Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: 2 WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES MANAGER MINERAL PIGMENTS Ith and Mental Hygie
27 is marked other i
r traumatic event, III marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) it and 2 should be fill Health and Mental H tem 27 is marked oth Be GEORGE W. REED ELSIE G. BROWN ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr CATHERINE LOUISE REED/WIFE 700 PORT STREET #102, EASTON, MD3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
DRUID RIDGE
CEMETERY 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/17/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fig. 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 st that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can Immediate Cause (Final Physician OHE WEEK MAC disease or condition resulting in death) /Medical Due to (or as a masequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed Due to (or as a consequence of): burial-1 Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No Ö 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ASSISTED Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify LIVING) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o this After this funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 No death. a/1 2 Accident Investigation 2 110 after death Director: / d in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide acility 29a. Certifier (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Canal Elight Cove 106 Earle Aug, Gaston Mil 2/601 n 24 hours after e Funeral Dire eletely filled in b Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely within 2. 29c. License numb 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RS/2+14 Easton MD 2/401 ynwood State Registrar **ORIGINAL**

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	for State	State	of Maryla	nd / Dep	artment of H	lealth and l	-		re Legi ie	DIC.	
	Registrar	. (0		Ce	rtificate of L	Death		Reg. I	No.	n	<u> 3880</u>
an/	Decedent's Name (First, Midd Decedent's Name (First, Midd			DIME	TD.C		2. Date of D Month NOVEME		Day Oo	Year	3. Time of Deat
al er	ROBERT 4a. Facility Name (if not institutio	LEON n, give street and nur	mber)	RUMBU		Location of Death			10 , 20.		1:45PM
.	FREDERICK MEI	-			FREDERIC		•	'	FRED:		CK
	5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B		1	9. Birth	place (State or Fore
	212-64-0171 Usual Residence of Decedent	1020	58	Yrs.			Sept.	23,	1952 [Vest	virginia
tor	10a. State 10b. Count	/	10c. C	City, Town or Lo	cation					T	10d. Inside City Lim
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					10f. Zip Code			109. (Citizen of W	hat Cou	ntry?
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Be	17. Father's Name (First, Middle,	Last)		1 10	CITICY III	18. Mother's Nan	ne (First, Middle	, Maide		<u>.1.•</u>	
욘	Robert Leon Run	mburg Sr.				Violet M	ae Gilb	ert			
	19a. Informant's Name/Relations	ship (Type, Print)		19b. Maili	ng Address (Street a	and Number or Rui	al Route Numb	er, City	or Town, Sta	ate, Zip (Code)
	Donna L. Rumbui	g/ Wife			Crown Str	eet, Mt.	Airy,	Mar	yland	217	71
	20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation	3 Removal from	State	cemetery, crei	sition (Name of natory or other plac	e)	Date	1	Location - C	•	*
	4 Donation 5 Other		Pir		e Cemeter	y 11/2	2/2010	Mt	. Airy	y, M	aryland.
	21. Signature of Funeral Service	P////	niek	/ \$	Name and Address tauffer F 621 Oposs	uneral H	ome P	A	riok	Mox	1 and 21
er	disease or condition resulting in death)	a. Due to	(or as consec	quence of):	031	7				+	NKNeu
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AMEND ITEM#23a, ptil, perphys, G910, 12/22/2010, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 November 20:00 PM Rodin Arthur Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery 7. Age (In yrs. last birthday, If Under 1 Year If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Min. Mayon 14 Pay, 1915 Newry) York 95 Director 093-16-3957 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Ty Yes 2 No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 20852 6121 Montrose Road USA items death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ò Completed by 1 Never Married 2 Married within 72 hours after Yes 2🗶 No altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give White 3 ₩ Widowed 4 □ Divorced Year or Dates any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Garment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Molly Polakoff Isaac Rudinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melanie Polk/Daughter 13618 Valley Oak Circle. Rockville, Maryland 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 K Removal from State 4 Donation 5 Other (Specify) 11/16/2010 | Pinelawn, New York New Montifore 22. Name and Address of Facilia ward Sagel Funeral Direction, Inc Signature of Funeral Service Licenses Cheenrie <u> 1091 Rockville Pike, Rockville, Maryland 20852</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Duit to for as a nonsequence off. attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an Coronary Artery Disease Jas page 2 autopsy performed? Yes 2 Matastatic Prostate Cancer certificate 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this s after death.

I Director: After this id in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury work' 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (10) TWO D0057884 November 15, 201030. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, Maryland 20852 Montrose Road. <u>Damien Dovle</u> 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMEND#1perMD11/30/10, EMW, MbCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Dorothy 2. Date of Death 3. Time of Death Renner Physician/ 1:20a M 2010 November Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthdav) Funeral Country) Maryland 1 □ M 2 🕱 F Director 218-24-3569 83 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d Inside City Limits 72 hours after death with the Maryland Director Examiner must be notified 1 Yes 2 K No Maruland Prince George's Silver Spring 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3142 Gracefield Road. #412 20904 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc and Mental Hygiene. is marked other than "natural", or i Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced Caucasian Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own. Home. Home Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rebecca Viola Rich John Secondo Santini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 15001 Donna Drive. Silver Spring, Maryland 20905 Donna Dwyer - Daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 11/17/2010 | Burtonsville, MD 21. Signature of Funeral Sovice Ligensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Ver New Hampshire Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Emphysema disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Discas Sequer tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) -transit Hospital or Attending Physician: The law requires that the death certificate be executed Hupertension Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death
Unknown Yes 2 🔀 No the 9 Unknown After this certificate has been signed by a funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Renal Disease 1 ☐ Yes 2 ☐ No 3 🛛 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Yes မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Director: / Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State) 24 hours a Funeral I Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier Loven 20 uthumana 059524 November 11, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 3110 Gracefield Road, Silver Spring, Maryland 20904

M.D.,

2. Registrar's Sign

Loveen J. Puthumana

31. Date filed (Month, Day, Year,

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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Wovember Physician/ 1915 PM Jeanne Ann Oppelt Ryan 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rockville Montzone HOSPITA Grove Advontist If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 2 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number Funeral Country) Missouri 1 🗆 M 2 💢 F Months Hours Min. 499-38-7197 **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🗶 No Dickerson Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20842 U.S.A. 2001 Thurston Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces ò 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Private Tax Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Isabel R. Scheltinga Edwin John Oppelt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2001 Thurston Road. Dickerson. Maryland 20842 <u> Mary L. Dolan - Sister</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Lincoln Crematory 11/23/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ft. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tril ute Funeral & Crem. Ctr a 1040 Rockville Pike, Rockville, Maryland 20852 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final Physician/ Respirator Failure disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 HNo Other: မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 65132 November 13,2010 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who con Rockville, MD 20850 medical Of Dr Zhana 31. Date filed (Month, Day, Year) State NOV 19 2010 Registrar

DHMH 17 Rev 7/2009

61

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ PHILIP L. RIZZO 21,2010 November A^M 1:38 Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 0 Montgomery Rockville Shady Grove Adventist Hospital 3 If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F July 23, 1924 Hours 207-14-5416 86 Pennsylvania ス Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ø Maryland Montgomery Germantown 1 🗌 Yes 2 😾 No Novembe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #410 20874 18003 Mateny Road United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married 1 X Yes 2 □ No f Yes, Give τωτω þ Year or Dates. WWII 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 077 marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) and Mental Hygiene Professor of Literature College Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Laura Fabrizio Luigi Rizzo it. Page 1 and 2 should be intrent of Health and Mentartant: If item 27 is marked njury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number #r/Pare) Route Number, City or Town, State, Zip Code) (Wife) 18003 Mateny Road Germantown, MD 20874 Marcia Rizzo Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If il any injury or o 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 22 Metropolitan Crem. Alexandria, VA 2010 21. Signature of Funeral Service License 22. Name and Address of Facility DeVol Funeral Home 10 east Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ ulmonary embolish Medical resulting in death) ue to (or as a consequence of) Examiner 6 months cancel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine eath co.... Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attendion abusiness. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrosis umonar 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No Yes 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 **(YN**o Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 026640 NOVEMBER 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Road, # 213, Gaitherburn, Mary and 20877 I. Schoenberger, MD 16220 31. Date filed (Month, Day, Year) 82. Registrar's Signature State NOV 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November PAUL STAMER 0109 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Talbot Easton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours 1 **X** M 2 □ F Director 74 Yrs. 05/27/1936 053-30-3202 NY Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b, County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗌 Yes 2 😿 No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8359 TARAN COURT 21601 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALESPERSON PLASTICS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MORRIS STAMER CLARA LEIFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA H. STAMER/WIFE 8359 TARAN COURT, EASTON, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place OXFORD CEMETERY 11/14/2010 OXFORD, MD ame and Address of Facility
LOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. FELLOWS, HELFENBELN & 200 SOUTH HARRISON ST. , EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease of linjury that initiated events Due to (or as a conseque ce of): the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death Day 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗘 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending Certificat 1 🗋 Yes 2 🗌 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature 6265

State Registrar

2s 5

219

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15

			1. Decedent's Name (i	(First, Middle, La	ist)			-	-				2. Date of D		Fan W	-i-U	3. Time o	f Death
	Physicia		James Rob	ert Str	ubel								Month Novemb		ay 16. 2	Year 010	4:15	iam I
	/Medic Examin		4a. Facility Name (If no			umber)			4b. City,	Town, or	r Location		110 V Chil		c. County			/ CAILL
	LXammi		Wilson He	alth Ca	re Cent	er			Ga	ithe	ersbui	ro			Mont	. o o m e	rv	
	Funeral	<	52°13'-40'-704		Sex		(In yrs. last	t birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of B (Month, D	irth		9. Birth	place (State	or Forei
	Director		213-04-704		1 ⊠ M 2□ F		65	Yrs.	Months	Days	Hours	Min.	May 20	, 1	945		intry) \ 7\land	
	ъ		Usual Residence of De										<i></i>					
	ylan how		10a. State	0b. County			10c. City, T	own or Lo	ocation								10d. Inside C	
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	h the	Director	10e. Street and Number	er					10f. Zip	Code				10g. C	Citizen of V	What Cou	intry?	
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<u>z</u>	Men Men arke	٩	Aaron Ja	mes Str	ubel						Lela	Thar	'P					
5	and and is m		19a. Informant's Name	ne/Relationship	(Type. Print)			19b. Maili	ng Address	(Street	and Numb	er or Rura	al Route Num	ber, City	or Town,	State, Z	ip Code)	
2	and salth		Elizabeth	B. Str	ubel (Spou						ay, D	erwood	, M	208	355		
5	of H of H roth		20a. Method of Dispos 1 ☐ Burial 2 🖾 0		70	. 04-4-	20b. Plac	e of Dispo	sition (Nar	ne of ther plac	ce)	D	ate	20c.	Location -	City or T	own, State	
	Pagnent nent int; I		4 □ Donation 5			1 State	1				i	11/3	16/201) A	.1exa	ndri	a, Vir	gini
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is it office Example in with the indifficit and once.		21. Signature of Fune	eral Service Lice	nsee	/	21	2	2. Name ar	nd Addre	ss of Facili	ty De V	ol Fund				-	
ב	Depa Impo any Is		of	into >	ph	1/4		- Ga) East	r pe	er Pa rg. M	TK D1	rive 877					
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	/Medical		disease or condition resulting in death)		- W.		er's D		se									
	Examiner			•		,	Lar Ca	,										
		ē	Sequentially list condition any, leading to immediate. Enter Underlyi Cause (Disease or injuthat initiated events	itions, ediate	D		consequen											
	ansit of de	Examiner	cause. Enter Underlyi Cause (Disease or inju	ing jury	_													
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5	eath certificate be executed attending physician and for use as the burial-transit	ian/Medical																
5	h cer endir use	2	IF FEMALE: 23b. Was decedent pr	regnant	23c. If yes, or				75-4						23d. Da	te of deli	very	
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5	arthi eral c	<u>ا:</u>	27. Manner of Death		28a. Date	of Injury	/ 28	Bb. Time o		28c. Injur Worl			28d. Describe				ану)	
5	ding:	흝	1 X Natural 2 ☐ Accident	5 ☐ Pending investigation		nth, Day,	Year)	Injury	м	Worl	k? Yes 2□	No						
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2	after Dire	Certification:	4 ☐ Homicide	determined	build	ding, etc.	(Specify)						City or To	òwn, Sta	ite)			,
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached to the completely filled in by the funeral director, page 2 should be detached to the completely filled in by the funeral director, page 2 should be detached to the completely filled in by the funeral director, page 2 should be detached to the complete to the complete that the complete the complete that the complete the complete that the complete the complete that th		29a. Certifier 1	Certifying P	hysician: To th	ne best of	f my knowle	edge, deat	h occurred	at the ti	me, date a	nd place.	and due to th	e cause	(s) and m	anner as	stated.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1 - State of Maryland State of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of Ma	arylan	-	artment of I r <i>tificate of</i>			ental Hy	giene Reg. No?	010	38817
			Decedent's Name	e (First, Middle, Las	st)						2. Date of De	ath	0:0	3. Time of Death
	Physici /Medi		PHYLLIS	IRENE SM	ITH						Month	ber	Year 2010	2134 PM
	Examir				Hospital			4b. City, Town, o					ounty of Deat	
- 300	Francis		5. Social Security N		•	e (In vrs.	last birthday)	If Under 1 Year			8. Date of Bir		ltimor	
	Funeral Director		216-40-6 Usual Residence of	5082	□ M 0701 □	<u>'1</u>	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da 02/16/	iy, Year) 1939		hplace (State or Foreign untry)
	yland now		10a. State	10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	e Mai	Director	MD	Baltimore	2	Cat	onsvil	le						1 XYes 2 ☐ No
	vith th		10e. Street and Nun		0.433			10f. Zip Code				_	n of What Co	untry?
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Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the flecker Evanicar must be motified at	þ		ed 2 Married	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			Was Decedent of Mas Decedent of Mas Res, specify Cub			Rican, etc.)		Black, White	e, etc.
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imore	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.				Removal from State	20b. P. Arde		sition (Name of natory or other pla emation			/2010		tion - City or T Ver, M	,
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Division of Vital Records,	To the Hospital or Attending Physician: The lawithin 24 bouts after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	Certification: To	2 Accident 3 Suicide 4 Homicide	6 ☐ Could not be determined		ury - At ho c. (Specify	me, farm, stre		.100		8f. Location (3 City or Tox		Number or Ru	ral Route Number,
	e Hospital 24 hours e Funeral	Medical (29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	ysician: To the best liner: On the basis of and manner sta	f examinat	wledge, death tion and/or in	occurred at the tivestigation, in my	ime, date a opinion, de	and place, a	and due to the ed at the time,	cause(s) a date and pl	nd manner as lace, and due	stated. to the cause(s)
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	Sta Registr		31. Date filed (Mont.	10.0	2. Registra	ars Signat	for	11						

DHMH 17 Rev 1/2001

Smith, Phyllis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11/07/2010 8:50 P MARY ELIZABETH SCRIBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Leonardtown St. Mary's Hospital Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🗓 F Min. 05/02/1920 SMD^{try)} Director 220-16-4967 90 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Charles Indian Head 1 ☐ Yes 2 ☐ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 6206 Hard Bargain Circle 20640 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 X Widowed 4 □ Divorced Year or Dates artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natur
injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry St. Mary's (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Catholic Church Cook. 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Davis Luke Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6206 Hard Bargain Circle, Indian Head, MD 20640 Rose M. Short - niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Gate ∕of Heaven 11/16/10 Silver Spring, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home 21. Signature Funeral Service Licens 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the diseas a or complications, or heart failure. I st only one t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complical Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition Medical resulting in death) Examiner typothermia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Congestive
Due to (or as a consequence of) Heart Physician/Medical Hypertension P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Day 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SCF Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death? To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation

To the Hospital or Attending Physician; The law requires that the death certificate be executed eral Director; After this certificate I filled in by the funeral director, pag within 24 hours a To the Funeral D

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ber

6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifler Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practionen To the Sent of my knowledge, de 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

D68923

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

24035 Three Notch Road, Hollywood, MD 20636 Vijaya Lakshni Guduri

31. Date filed (Month, Day, Year) State Registrar

Medical

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month 00:45 AM Margie 11 3 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Sprin shell Cantere Montgomer Silver 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Year Months Days Hours 1 □ M 2 □ 229-07-6830 100 March 19.1910 <u>Virginia</u> Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1900 Olivine Court 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No 3 X Widowed 4 □ Divorced Ahrican-American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Private 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harvey David Claytor Lena Eliza Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald W. Smith - Son 1900 Olivine Court, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 12/07/2010 Arlington, Virginia 4 Donation 5 ☐ Other (Specify) Arlington Natl Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD20904 23a. Part 1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheiners Sequentially list conditions, If any, leading to finnedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last current Due to (or as a consequence of) yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes

Physician /Medical Examiner

Department of Health a Important: If Item 27 Is any injury or other trains

Physician

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Examine

Physician/Medical

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Certification:

Medical

r than "natural", or items 23a or 28a-f shov

Il Hygiene.

Pages 1 and 2 should be filed vent of Health and Mental Hygis ant: If Item 27 Is marked other

permit.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

/Medical

or Attending Physician: The law requires that the death certificate be executed and I physician a s the burial-1 attending p for use as t ģ been signed be should be deta cate has l page 2 s certificate After this of funeral dire To the Hospital or many within 24 hours after death.

To the Funeral Director: Aft

IF FEMALE: 23b. Was decedent pregnant in the past 12 mon 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

autopsy perform 1 ☐ Yes 2 **1**No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 ☐ Yes 2 ☑ No 27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 Suicide

1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of

2 ER/Outpatient 3 DOA 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 □Yes 2 □No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

29c. License number 467624 29d. Date signed (Month, Day, Year) 11/16/10

SUHANA M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AFROOZ, Ral Spring

Be 31. Date filed (Month, Day, Year)

5 Pending

investigation

determined

6 ☐ Could not be

32 Registrar's Signature

State

3

D. 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #9 Per FH G910 12/29/10 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November Robert E. Sanders Z'ear 8:26AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Doctor's Hospital -Lanham Lanham Prince Georg's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex 1 M 2 D F **Funeral** North Carobina Days Hours Min 3/97/1945 Months 241-70-6717 65 **Director** Virginia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Prince George's Glenarden #613 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 8106 MArtin Luther King Hwy. 20706 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🎽 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Black event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Dept. of Housing life. DO NOT use retired) 2 Years Elementary/Seconday (0-12) and Mental Hygiene. Maintenance SUpervisor D.C. Government Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Dan Carter Sanders Aloraz Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 106 Martin Luther King Highway #613
Glenarden, Maryland 20706 Rachel Sanders/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Riverdal<u>e Park</u> 11/23/10 Riverdale, MD 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Latney's Funeral Home, Inc. cc0278 3831 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ POSIS disease or condition resulting in death) week Medical Examiner Surmentially list non-litions Examiner if any, leading to immediate cause. Enter Underlying signed by the attending physician and de detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal deat
Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has page 2 autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide after death Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOODLOES PROMISE DRIVE BOWIE MD 20120 12700 Registrar's Signat State 18 2010 MOV Registrar

10-08948 Jaime Solivan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

iiiie Oolivaii		1-For State Of Maryland / Department of Health and Mental F		2010	00061
Physici	an/	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Dea	teg. No.	3. Time of Death
edical Exam				Day Year r 22, 2010	0628 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Deatl	
		Shady Grove Adventist Hospital Rockville		Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Bi	rth(MM/DD/YYYY) 9. Bir	thplace (State or
Director		Months Days Hours Min	n.	Foreig	n Puerto
		599-05-8796 1X M 2 F 24 Yrs. Usual Residence of Decedent	May 2	2, 1986 Co	Rico
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
∂α ≱ .	_	Manual and Monte among			1 Yes 2 X No
rylan	cto	Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code	I 1	0g. Citizen of What Cou	otry?
14.38 ne Maryland or 28a-f show)ire			•	•
with the Maryland is 23a or 28a-f she notified at once	al	20613 Summer Sweet Terrace 20876	Coosify Voc or No	United S	can Indian, Black,
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	can ingian, black,
ter de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 X Yes 2 No specify: Pue	rto Pio	an Specify: H	ispanic
irs af tural	l by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business/	
2 hou "nad	tec	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use ref		Tool raing or Edulicos	, rado (r y
36 hin 7 e. than	ğ	12 Student		College	
d with	Completed		e (First, Middle, I	Maiden Surname)	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be (Jaime Solivan	Judith	Morales	
21 ould I Mer mar	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			, Zip Code)
MD and 2 sho alth and m 27 is		Judith De Armas/Mother 20613 Summer Sweet Te	rrace,	Germantown,	MD. 20876
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death pergrament of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or item injugy or other traumatic event, the Medical Examiner must b		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
nt of other		A Bottai 2 Octimation 5 Nemoval non-State	20/2010		M1 1
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Donation 5 Other Specify: All Souls Cemetery 11/ 21. Signature of Function Service Licensee	79/2010	Germantown	, maryiand
Be Ped dirin		Alloward Slauden 10 East Deer Park I			MD 20877
Physician		296. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone intoxication			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, b			
	ner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
0	Examiner	(Disease or injury that initiated			
recuted and transit	Ä	events resulting in death) Last Due to (or as a consequence of):			
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Box 687 death certific the attending p	Physician/	4 Pregnant at time of death 5 Other (Specify)			
Be dea	Į,	Unknown			
Records, P.O. The law requires that the ficate has been signed by	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
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ord w required should	ompleted		24a. Was autop		opsy findings available ompletion of cause of
ecc he lav ate ha	Ē		perfor 1 ✓ Yes	med? death?	
II R in: T rtifica for, pi	ပ	25. Was case referred to medical 26.Place of Death (Check			2 110
Division of Vital Records, tal or attending Physician: The law requirs after death. al Director: After this certificate has been ided in by the funeral director, page 2 should	o Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursin	ng Home 5	Residence 6 Other	
of vig Ph	-1	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
Sion of Attending Ph r death. ector: After t by the funeral	ţ	Natural 5 Pending Fd 11/22/10 Fd 0546 hrs 1 Yes 2 No	unk		
r Atto	<u></u>	28e. Place of Injury - At home, farm, street, factory, office building etc.	28f. Location (S	Street and Number or Rui	al Route Number, City
Division of the property of th	Certification:	determined (Secretal model demons	or Town, S Ter Ge:	^{tate)} 20613 Sur rmantown. M	nmer Sweet
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and			
the I	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
F. 2 F. 9	≅	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	th, Day, Year)
1		(al 111 1 At - ref) O.C.M.E.		November 23, 20	10
		30. Name and address of person who completed cause of death (Item 23a)			
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	201		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
Regist		MAY 3 (1 2010)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 22. 2010 Jane Idella SMITH A)M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 822 Lanvale Street Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign nth, Day, Year) t. 11,1923 213-18-9888 1 □ M 2 🛣 F Months Days Hours Director 87 Yrs. Maryland Sept. Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Washington Hagerstown Maryland 1X Yes 2 ☐ No 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21740 822 Lanvale Street U.S.A. items ? within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2X No Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 🛮 Widowed 4 🗆 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within 72 ntal Hygiene.
ed other than "
event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) ribbon manufacturer hanker Be permit. Page 1 and 2 should be filled Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, Once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shank Minnie G. Roser Xerierus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry J. Hays - daughter 934 Grapevine Road, Martinsburg, West Virginia 25405 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State November Rest Haven Cemetery Hagerstown, Maryland 4 Donation 5 Other (Specify) 2010 Signalus of Funeral Service License Minnich Funeral Home 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 2174 $0\,$ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury Examine Director (or as a consequence ut): this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day g 🗌 Unknown Part II. Other sulting in the underlying use given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 **N**No ြု 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manper of Deat 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) Natural Accident 5 Pending s after death 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examinet, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the lawithin 2. only one Sian 29d. Date signed (Month, Day, Year) 30. Name and add 141-2

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

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			State Registrar				Cer	tificate of I	Death		Reg. No	2 U i	U	3 3 8 2 3
	Physicia Medi		1. Decedent's Nam	Fred	evick	Sull	ivai	1		2. Date of Do Month	eath Da	y L	Year	3. Time of Death $7:50 \text{ QM}$
	Examir	ner	· ·		ive street and number)			4b. City, Town, o		ath	i	. County o		1
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4-	Director		726-12-1		1 \(\textbf{X} \) M 2 \(\textbf{F} \)	86	Yrs.	Months Days	Hours Mi	sept.	¹ / ₅ ,	1924	Coun	
	ind show at	اة ا	Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Loc	cation						0d. Inside City Limits
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9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examiner must be notified at once.	ゑ	11. Marital Status 1 Never Marr 3 Widowed	ried XX Married	12. Was Decedent Armed Forces? 1 Yes XX If Yes, Give Year or Dates.		l If	Vas Decedent of H Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No erto Rican, etc.)		14. Race Black Specify:	, White, e	etc.
Baltimore, Maryland 21215-0036	/ithin 72 hou lene. r than "nati the Medica	Completed	(Spe Elementary/Sec 12th		Education grade completed) College (1-4 or t		(Give k	ent's Usual Occup ind of work done of NOT use retired)		•	l .	ind of Bus		dustry
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, Mar	nd 2 shou lealth and m 27 is m			Henkel	(Type, Pnint) - Step-Son	1	19b. Mailin 24972	g Address (Street 2 Cuckolo	and Number or H	Rural Route Number	er, City or , MD	Town, Sta 206	ate, Zip C 36	code)
timore	. Page 1 a ment of H tant: If ite jury or oth		20a. Method of Disp 1 □ Burial 2 ※X Donation		CXX moval from State	cem	ce of Dispos netery, crem Cure	sition (Name of atory or other place Inc.	ne)	Date ov. 23, 201		rlanc	-	
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	Physician/ Medical Examiner		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List only Final	mplications that caused one cause on each line a. Met 7 Due to (or as	ntat	ic	r the mode of dyin		ac or respiratory ar	rest,			Approximate Interval Between Onset and Death
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, Le. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. Within 24 hours after death. Completed filled in by the funeral director, page 2 should be detached for use as the		IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal d	eath 3 🗌	Ectopic pregnand Other (specify)	у			23d. Date Mont		ry Day Year
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Division	oital or A rurs after ral Direc illed in by		4 U Homicide	determine	building, etc	. (Specify)				28f. Location (S City or Tow	n, State)			·
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	Note the within the community of the com		29b. Signature and t	title of certifier	emree			29c. License	number		29d. Date	e signed (
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#25perMD, 11/24/10, EMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1:15am Sol Sobel November 21. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F Months Hours 074-16-5533 Yrs Director New York 90 April 24,1920 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f ehoveny injury or other traumatic event, the McJical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5800 Nicholson Lane, #803 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 Ø No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: ۾ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Artist Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Max Sobel ၀ Jennie Lechovsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5800 Nicholson Lane. #803, Rockville, MD 20852 <u> Leah Sobel - Spouse</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Defiation 5 ☐ Other (Specify) Garden of Remembrance 11/23/2010 Clarksburg, Maryland 21. Signature of Funeral Service Licen-22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD20904 ples ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, p. List only one cause on each line. 23a. Part1. Enter the disea shock, or heart fillure. Approximate Immediate Cause (Find disease or condition resulting in death) Physician Atheroscleratio /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): as the burialthe attending physicien Box 68760 Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9□ Unknown 9 □Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2X ER/Outpatient 3 DOA Alter thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medicai Certification: 5 Pending investigation 1 Natural 2 Accident To the Hospitel or Attending within 24 hours after death.

To the Funerel Director: Alte completely lilled in by the fun 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicida Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10mste Name and address of person who completed cause of death (Item 23a) (Type, Print) Kville Pike, G-100, Rockville, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CENTER LAYHILL SILVER SPRING MONTGOMERY Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ▼ M 2 □ F Months Hours Min GERMANY Director 84 075-20-7498 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2 😿 No MD. MONTGOMERY ROCKVILLE 10e. Street and Number ms 23a or must be r ò 10f. Zip Code 10g. Citizen of What Country? Funeral 14519 BARKWOOD DR. 20853 U.S.A. 12. Was Decedent Ever in U.S. "natural", or iten ledical Examiner r Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 XYes 2 [If Yes, Give Year or Dates. 2 🗆 N Maryland 21215-0036 1944-1<u>946</u> 1 Yes 2 XNo Specify. 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N INSURANCE BROKER INSURANCE CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ LEO SADEL MARTHA **BESSER** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant; If item 27 is y injury or other trau INGE SADEL/WIFE 14519 BARKWOOD DR., ROCKVILLE, MD. 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State CHAMBERS 4 ☐ Donation 5 ☐ Other (Specify) <u>11-19-</u>2010 permit. Poe artm De artm Importa any inju 21. Signature of Funeral Service Dicensee FUNERAL HOME & CREMATORIUM, P. A ambusa M00091 CLEVELAND AVE. RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the a Id be detached for 1 Yes 2 L 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law in within 24 hours after death.

Or the Funeral Director: After this certificate has E completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 1 **Division of Vital** 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes ျ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifa 29d. Date signed (Month, Day, Year) 6828 30. Name and address of of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Ying Mei P. Shieh 18, 2010 Nov. 5:33PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 14725 Soft Wind Drive North Potomac Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept 30 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕱 F Months Hours Country)
Taiwan Yrs 218-90-9571 101 Sept ´1909 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2X No MD Montgomery North Potomac 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral ral", or items 23. Examiner must 14725 Soft Wind Drive 20878 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. \$ 1 Never Married 2 Married ☐ Yes 2x No within 72 hours after 1 Yes 2 No Specify: If Yes, Give Specify: Asian 3

Widowed 4 □ Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F 1 and 2 should be fill the stand Mental to the stand Mental to the stand marked မ Sung-Shou Pong Sung-Mei Liu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan S. Lee/Daughter 14723 Soft Wind Dr., North Potomac, MD 20878 permit. Page 1 a Department of H Important: If ite 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Nov. 27
Metropolitan Crematory 2010 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, 22. Name and Address of Facility
Francis J. Collins Funeral Hom
500 University Blvd. W., Silver 21. Signature of Funeral Service/Licensee Home Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate nterval Between Opset and Death Immediate Cause (Final Physician/ Cardiac Arrhythmia disease or condition Medical resulting in death) Examiner Coronary Artery Disease 20 yrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-Physician/Medical as attending IF FEMALE use yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 🛣 No 9 ☐ Unknown 9 Unknown ed by the a s been signed by should be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 YeN 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Tes ပ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1x Natural work?
1 Yes 2 No after death.

I Director: Aft
d in by the fur 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined in 24 hour.
in 24 hour.
io the Funeral Dr
completed filler Medical 29a. Certifier 1 🔀 Certifying Physician; To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52457 Nov. 18, 2010 Who 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mo - L _ 31. Date filed (Month, Day, V 9001 Shady Grove Ct, Gaithersburg, MD 20877 Mo-Ping Chow, State

Registrar

21215-0036

Baltimore, Maryland

68760

Box (

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month November 17,2010 Physician/ Nathan Schwartz 11:40AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs.-last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🛣 M 2 🗆 F New York 578-38-0458 02722/1913 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director notified 1x Yes 2 ☐ No MD Montgomery Kensington 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 4414 Woodfield Road 20895-4234 **IISA** 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. WW2 Army 1. Yes 2X No Specify: "natural", Completed 3X Widowed 4 ☐ Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clothier Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H t, Page 1 and 2 should be fill treent of Health and Mental tant: If item 27 is marked or မ Max Schwartz Rachel Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Schwartz Sarino -daughtet 4414 Woodfield Road Kensington MD 20895 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If is any injury or c N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Garden 11/21/2010 Olney MD 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Funeral Service Licenses M01163 1091 Rockville Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** Sigmoid Volvulus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 🗌 Unknown P.O. ρŚ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page performed? Yes 2 No Hypotension 1 Yes 2 No Hospital or Attending Physician: **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No ျှ 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1X Natural 5 Pending injury s after death.

I Director: After din by the fur 1 Yes 2 No 2 Accident Investigation To the Hospital or Atte within 24 hours after de To the Funeral Directo 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D64100 11/17/2010 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji 1500 Forest Glen Road Silver Spring MD 20910-1484 31. Date filed (Month, Day State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wilma 6, 2010 Stultz 1047 /Medical Nov. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Univ. of Maryland Medical Ctr Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** Months 1 □ M 2 X F Days Hours 219-32-5346 76 Director June 3, 1934 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner rust be notified at Maryland Carroll Westminster 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene.

Int: If Item 27 Is marked other than "natural", or items 23a or 269 E. Main Street, apt 1 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Completed by Specify Specify: white 3 Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residential Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Thomas Good Gladys Evelyn Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin L. Robertson, daughter 560 Jasontown Road, Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Pk 11/10/2010 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home inter 91 Willis Street, Westminster, MD 21157 83a. Part U Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Bowel Obstruction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760 attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. 9 Unknown 9 Unknowi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1√2 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 11 Yes 2 □ No 1

✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐No death. investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nov. 8, 2010 D62237 WJL 2+1

Registrar DHMH 17 Rev 1/2001

State

Murthi 22 S. Greene St. Baltimore, Md 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sarah B

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38829 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AUGUSTA SAFFRAN 2010 November 8:20P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months May 17. 1928 1 ☐ M 2 🟋 F 82 Hours 577-40-0734 Washington, DC **Director** Usual Residence of Decedent 28a-f shov 10b. County "natural", or items 23a or 28a-f sho ediral Examiner must be notified at 10a. State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Prince George's Marvland Beltsville 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 13114 Greenmount Avenue 20705 United States within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc Never Married 2 - Married þ Maryland 21215-0036 1 Tes 2 No Specify White If Yes, Give Year or Dates Specify Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) I Hygiene. Elementary/Seconday (0-12) Draftsman Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever Robert Edwin Saffran Louise Shalk permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Diane Ruscher -niece 10949 Bellhaven Blvd. Damascus, Maryland 20872 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 11/20/2010 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer Bonald WdresBorg Wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Peritonitis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Endometrial Carcinoma months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary Emboli 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? Yes 2 X No page 1 ☐ Yes 2 🗓 No hin 24 hours after death.

the Funeral Director: After this certific inpleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 only on

Registrar

DHMH 17 Rev 7/2009

State

d title of

1 9 2010

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Sign

29b. Signat

Lee E. Schwab, M.D. HCH 1500 Forest Glen Road Silver Spring, Maryland 20910

29c. License number

1) 22990

29d. Date signed (Month, Day, Year)

November 18, 2010

10-08958 Judy Sandra Strickland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Augusta.	10			1	1	-	1	1

		1- For State Certificate of Death Reg. No.
Physicia Medical Exami	n/	1. Decedent's Name (First, Middle, Last) Judy Sandra Strickland 2. Date of Death Month Day Year November 22, 2010 3. Time of Death 1105 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charles
Funeral Director		5. Social Security Number 579 08 1112 6. Sex 1. Age (In yrs. last birthday) 47 yrs. Months Days Hours Min. 9-24-1963 Trinidad
459 und show any nce.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Charles Waldorf 1xxyes 2 No
with the Maryland ms 23a or 28a-f sho	Director	10e. Street and Number 2737 Redline Place 10f. Zip Code USA 10g. Citizen of What Country?
fter death ", or iter	Funeral	11. Marital Status 1
5-0036 led within 72 hours al Hygiene. other than "natural the Medical Examin	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook Private
21215-0036 suld be filed within 7 Mental Hygiene. marked other than	æ	17. Father's Name (First, Middle, Last) Thomas Hutchinson 18. Mother's Name (First, Middle, Maiden Surname) Theodora Ash
and 2 should lealth and Me tem 27 is ma traumatic ev	으	19a. Informant's Name/Relationship (Type, Print) Marsha Strickland/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2737 Redline Pl.Waldorf, MD 20602
Baltimore, ME permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other trauma		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Cemetery 20c. Location - City or Town, State 12/2/2010 Waldorf, MD 22. Name and Address of Facility Friscoe Onic uneral fome
	1	Symplety Buschelonec 2294 Old Washington Rd. Waldorf, MD 20601
Physician /Medical Examiner		23. Part I. Enter the d'ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death
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Box 68760, e death certificate be the attending physicied for use as the buried for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
, P.O. B ires that the d signed by the	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown
cords aw requi	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 \[\begin{align*} No \\ Yes 2 \[\exists \] No
Vital Rec ysician: The I	BB	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other, Nursing Home 5 Residence 6 Other.
n of V ding Phys h. After thi funeral di	on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Company Subject ingested drug
Division of N Hospital or Attending Ph 24 hours after death. Funeral Director: After t	Certification:	2 Accident Investigation Investigation Fd 11/22/10 Fd 9:55 am 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street, and Number or Rural Route Number, City Could not be determined determined determined Could not be determined determi
To the Hospital within 24 hours To the Funeral completely fille	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To witi	Med	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)
RB		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
St Regis	ate	

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of co

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Damouni



26744

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William >

Hwy., Suite

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar#19a, per F.H., 11/17/10, BA Amended item Certificate of Death WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 11/15/2010 Physician/ 8:44 P George Francis Smoot, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Berlin Catered Living . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Months 1 🔀 M 2 🗆 F Hours 04/13/07 11/92/9 Wash. DC 577-32-2824 81 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State Director 1 🗆 Yes 2 No Berlin MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1135 Ocean Parkway Unit 14A 21811 IISA ral", or items ! Examiner mus 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3€XWidowed 4 □ Divorced "natural" Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. Tank If item 27 is marked other than "naturury or other traumatic event, the Medical ury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) defense mapping agency cartographer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Margaret Meehan George F. Smoot Sr. 19a. Informant's Name/Belationship (Typg, Print) Juliet Wilkerson Daughter Valerie Stevens (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenfeild Ave., Glenolden, PA 19036 601 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important, If ite
any injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State 11/17/201 Millsboro, DE lst State Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature Frier I Service Licenses 108 William St. Berlin, MD 21811 Misor 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons t and Death Immediate Cause (Final Due to (or as a consequence of) Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death g Unknown g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) ᅆ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how Injury occurred Certificate: 1/Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAUSBURY mer un St BA5TI 080 1RASSO W

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, the Madeol Eventina must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sta

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Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)				18. Mother's	s Name (F	First, Middle, I	waiden S	urname)				
ဥ	Phillip Segal				Ant	toine	ette	Nadl	er				
	19a. Informant's Name/Relationship (Type. Pr			g Address (Street a	and Number	or Rural F	Route Number	r, City or	Town, State,	Zip Code))		
	Elizabeth N. Shlonsk	ky/daughter	12705	5 N. Comm	ons Wa	ay P	otomac	, Ma	ryland	208	54		
Ì	20a. Method of Disposition	20b. Pi	1	sition (Name of atory or other place		Date			ation - City or				
	1 ☐ Burial 2 【Cremation 3 ☐ Remove	ai from State I				14/40	10040						
	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Fina.		ney Crema					dbine,		yland		
	21. Signature of Funeral Service Licensee	,	GÖ	ing Home	Cremat	tion	Servic	e P.	O. Box	784			
	Juanita X4K	omas MOOS	957 Bev	verly L.	Heckro	otte,	P.A.	Clar	ksvill	e, M	210	29	
	23a. Part Lenter the disease, or complication shock or heart failure. List only one cau	s that caused the death	. Do not ente	er the mode of dyin	g, such as ca	ardiac or r	respiratory arr	est,		Appro	ximate al Betweer	n	
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Completed by Physiciar	Part II. Other significant conditions contributi	ng to death but not resu	iting in the up	derlying cause give	en in Part I		23e Did to	bacco ue	e contribute to	the caus	se of death	1?	
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Ě	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 286	 Place of Injury - At hor building, etc. (Specify 	me, farm, stre	et, factory, office		281	f. Location (St City or Town	treet and	Number or Ri	ural Route	e Number,		
Medical Certification: To		3, (-, ,)					, 5. 10411	.,)					
<u> </u>	29a. Certifier 1 Certifying Physician	: To the best of my know	wledge, death	occurred at the tin	ne, date and	place, an	d due to the d	ause(s)	and manner a	s stated.			
gi	(Check only 2 Medical Examiner: Cone)	In the basis of examinat and manner stated.	tion and/or inv	estigation, in my o	pinion, death	occurred	l at the time, d	ate and	place, and due	e to the ca	ause(s)		
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			ン		65870			Nove	ember 1	15, 2	2010		
	30. Name and address of person who complet		23a) (Type, P	Print)									
	Melissa E. Blakeman,	M.D. 6000	Execu	tive Blv	d. Sui	te 6	25 Rock	cvil1	e Mar	vlan	d 208	352	
е	31. Date filed (Month, Day, Year) NOV 19 2010	32. Registrar's Signat	ure -	4	,					7	W AVC	7-16-	
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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 16,_ Physician/ 8:20 P M 2010 Shwe Hla Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Country) Burma **Funeral** (Month, Day, Year) OV 17, 1937 1**X** M 2 □ F Months Days Hours 219-27-4073 72 Nov **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2x No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Burma 20877 7 Briarstone Lane death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. þ Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Asian Completed 15 Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) within 72 h and Mental Hygiene.

is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Government Administrative Aide 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any injury or other trans-೭ Pwa Wein Daw 00 **Kyaw** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Briarstone Lane Gaithersburg, Maryland 20877 Lin Naing/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Final Journey Crematory 11/22/2010 Woodbine, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Sign were of Funeral Service Licensee Thomas M00957 1 Manila 23a. Part Denter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ End stage kidney disease Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death Other (specify) 2 No ed by the a detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? היושי ניווא טפרווזוכמte has been signed l funeral director, page 2 should be det ρ 1 Yes 2 No 3 Probably 4 Munknown CHF Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an MI autopsy performed? death? 2 **X**N certificate Yes Yes HTN26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 ☐ Yes 2 🖾 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) Hospice မ 28b. Time of 28c. Injury at 28d. Describe how injury occurred 28a. Date of injury 27. Manner of Death Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 🗶 Natural 5 Pending Investigation 6 Could not be after death Accident in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours at Funeral D leted filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Funel

completed fil ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certifier 29c. License number ٥

State Registrar

Barke

egistrar's Signature

reserva

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Debrah Miller, CRNP

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R143201

6001 Muncaster MIll Road Rockville, Maryland 20855

			1_ For Amend #23a	State of M Part II, 1						Mental Hy a1	giene	0.0	e.	
			Registrar 1. Decedent's Name (First, Middle, La.				imca	ile of Di	caur	2. Date of De		- 211		_383 .
	Physicia				Suggs					Novembe		2018	ς ^{3.}	Time of Death 5:00p M
	Medio Examin		4a. Facility Name (if not institution, give		Daggo		4h Cit	ty Town or I	ocation of Deat		4c. County of Death			3.00p ···
-	Exami	lei	Casey House	,			Rockville					Montgomery		
	Funeral		5. Social Security Number 6. S		e (In yrs. last	birthday)			If Under 24 Hrs			9. 1	Birthplace	(State or Foreign
Ш	Director		092-38-8539	□ M 2 X F	62	Yrs.	Months	s Days	Hours Min.	Mar 16	⁴ 134	18 N€	W YC	rk
	d ow t	_	Usual Residence of Decedent 10a. State 10b. County		100 City 7	Town or Loc							1.0	
	ryłan I-fsh ieda	cto		0027	Toc. Oity, 1			ville				10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
	or 288	Director	Maryland Montgor 10e. Street and Number	исту		- F	-	Zip Code			40- 00			T LI fes 2 LI NO
	ith th	<u>ra</u>	9701 Medical Cent	er Drive	ll '			208	250	1		Og. Citizen of What Country? United States		
	ems r.mu	Funeral	11. Marital Status	T		13. V	Vas Dece			pecify Yes or No-		14. Race - Ar		
9	or it	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀	No	lf	Yes, spe	ecify Cuban,	Mexican, Puert	o Rićan, etc.)		Black, W		aran,
8	ırsafi ıral", IExa	ed	3 🗌 Widowed 4 🔀 Divorced	If Yes, Give Year or Dates.		1	☐ Yes	2 🔀 No	Specify:			Specify:Afi	rican	-American
5-0	2 hou "nati adica	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	ent's Us	ual Occupat	ion ring most of wor	rkina	16b. Ki	nd of Busines	ss Industr	у
121	thin 7	[등	Elementary/Seconday (0-12)	College (1-4 or 5	5+)	life. DC) NOT u	se retired)		9				
7	d wil	Be C	17. Father's Name (First, Middle, Last)	5 <u>+</u>		Atto	rne	-	10 Mail 1 M	(F" + A 4" + 1"		Govern	ment	
an	be file	욘	Andrew Mor	ci c					Barba	me (First, Middle,	rell	,		
$\overline{\Sigma}$	ould ould mark		19a. Informant's Name/Relationship (7			10h Mailin	a Addroi	ss (Stroot on		ral Route Numbe			Zin Cadal	
Š	12 sh alth ar 27 is rtrau		David Suggs/son	,,,	- 1					hersburg				
ē,	1 and of Hea item		20a. Method of Disposition			e of Dispos	sition (Na	ame of		Date		cation - City		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1		,	other place) Cremat		17/2010	Woo	odbine,	Mar	vland
alti	permit. Departn Imports any inju once.		21. Signature of Funeral Service Licen								1			
8	8 8 E 6		Quanta RH	mas	M009	57 Be	ver.	ly L.	Heckrot	te, P.A.	Čla	rksvi]	Ĭê, '	84 MD 21029
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused ne cause on each line	the death. [Do not enter	r the mo	de of dying,	such as cardiac	or respiratory arr	est,			roximate rval Between
	nysician/	8 9	Immediate Cause (Final disease or condition	Septi	cemia									et and Death
	Medical Examiner		resulting in death)	Due to (or as a	a consequen	ce of):								
	LAGITITICI	<u>.</u>	Sequentially list conditions,	D	tinal		uct:	ion					da	ys
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	cate phys s the			d										
Division of Vital Records, P.O. Box 6876	certifi nding use a	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy		_					23d. Date of o	delivery	
Š	leath e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 █ X No	1 Live Birth 4 Pregnant a			Other (s	pregnancy specify)				Month	Day	Year
Ö.	requires that the death certificate been signed by the attending phy should be detached for use as the	Completed by Physician/Med	9 🗌 Unknown	9 Unknown										
<u>o.</u>	s that gned se del	þ	Part II. Other significant conditions of	-			, ,	g cause giver	n in Part I.	23e. Did to	bacco u	se contribute	to the cau	use of death?
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Ξ	Physi this c al dir	은	1 ☐ Yes 2 ☐XNo 27, Manner of Death	1 Inpatie	ent 2 ER	/Outpatient				lome 5 Resid			ecify) H	ospice
n o	ding h. After funer	ate	1 Natural 5 Pending	(Month, Day	, Year)	injury	м	28c. Injury a work?	nt es 2 □ No	28d. Describe h	ow injury	occurred		
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Σį	al or / s after Dire		4 Homicide determined	building, etc		, ,	,	,,		City or Tow		Tramber of t	arar riout	o rearribol,
_	pspite hours ineral	lical		sician: To the best of										- 1
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. with Personal Director, After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Exam only one) 3 Certifying Nurs	ner: On the basis of ex se Practioner: To the	kamination ar best of my kn	nd/or investi nowledge, de	gation, in eath occi	n my opinion, urred at the ti	death occurred a ime, date and pla	at the time, date a ace, and due to the	nd place, cause(s)	and due to the and manner a	e cause(s) as stated.	and manner stated.
	Note To t		29b. Signature and title of certifier				29	c. License n	umber		29d. Date	e signed (Mor	th, Day, Y	(ear)
			1 Globar 1	7				D371	42		Nov	ember	15,	2010
5			30. Name and address of person who				,							
	Stat		G. Coleman, M.D. 31. Date filed (Month, Day, Year)	32. Régistra	r'o Pianaturo				e, Mary	<u> 1and 208</u>	50			
	Registra	ar	31. Date filed (Month, Day Year) 9 2	010 32. Régistra	A-AL	9. 10	arks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ STURTZ 2010 Medical a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner of Hagerstown washington Hagerstown Healthcare 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number If Under 1 Year **Funeral** 1 M 2 🗆 F Months Min (Month, Day, Country) Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director Cumberland Allegany 1 Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21502 E. USA 701 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Yes 2 No δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.

27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) construction Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic ever ್ತ Sturtz Carl Leona Kay Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14303 Ellerslie RD POBOX 143 Ellerslie MO 21529 Kathy Thompson DGH 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date PALO ALTO HILLEP 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 11-23-2010 HUNDMAN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HARVEY H. Zeigler Funeral 21. Signature of Funeral Service Licenses Home INC 169 Clurence St HYNDMAN PA 15545 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Preumoni month piration disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner sphagia Sequentially list conditions, it any, hearing to immediate cause. Enter Underlying Examine Due to or as a unamuluence of the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director. After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Dementio <u>Alzheimers</u> Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending iniury 1 Natural ☐ Accident ☐ Suicide Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) è November 19,2010 D4745

Registrar
DHMH 17 Rev 7/2009

State

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DO

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

County

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Saathoff Physician/ Corbet Bobby Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Western MD Regional Medical Center Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1 1 / 20 / 1952 Mary Land 1 X M 2 🗆 F 58 216-66-1123 Director Usual Residence of Decedent 28a-f shov 10a State 10c. City. Town or Location 10d. Inside City Limits iled within 72 hours after death with the Maryland Examiner must be notified at Directo Mt. Savage Allegany 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21545 items 23a USA 12709 Portertown Road. NW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Yes Give "natural", 3 Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Retail other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked of ည Saathoff Thelma Grace pe 1 Clarence Henry Page 1 and 2 should and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 12709 Portertown Road, NW, Mt. Savage, MD Thelma G. Saathoff Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Restlawn Mem. Gardens 11/29/2010 LaVale, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, . Signat re of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ARDIAL INFARCTION Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner DRONAR Sequentially list conditions, Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has the funeral director, page 2 s autopsy performe death? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be ပ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation 24 hours after death Funeral Director, Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an D50844

Registrar

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30. Name and ad

MD

912 STOW DILIVE CUMBERLANDIND 21502

of person who completed cause of death (Item 23a) (Type, Print)

OVENZIA J

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14^{Day} Physician/ Month GEORGIA EASTMAN THOMAS 2010 3:45 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** THE GARDENS AT WILLIAM HILL MANOR TALBOT EASTON 7. Age (In yrs. last birthday)

93

Yrs. If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛣 F Months Days Hours 1171471917 Director TX 217-34-1645 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director TALBOT 1X Yes 2 No MD **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other transary injury or other transary. Funeral 28605 CLUBHOUSE DRIVE 21601 UNITED STATES Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE Completed 3 X Widowed 4 □ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GEORGE MILES EASTMAN ANNA MARGARET SCHILLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 LONDONDERRY DR., EASTON, MD MARGARET A. SHARP/DAUGHTER 21601 20a. Method of Disposition 20b. Place of Disposition (Name of Date CHESAPEAKE CREMATION 11/16/2010 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signatore of Fall FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 200 SOUTH HARRISON ST., EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Unknown signed by Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anascara autopsy perform 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) Assist. Liviv 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation after death Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number R077623 Show Col 2010

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State

Registrar
DHMH 17 Rev 7/2009

Cynwood

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kystal L Thomas

31. Date filed (Month, Day, Year) NOV 16 2010

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Reg. No. Reg. No.	9
		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	_
Physici /Medic		JOSEPH W. TOTH	M
Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince 6	5
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1951 9. Birthplace (State or Foreign Months) 1951 9. Birthplace (State or Foreign Months) 1951 9. Birthplace (State or Foreign Months) 1951 1	
Director		182-42-0824 XM 2 F 59 Yrs. World's Days Hours MARCH 07, PENNSYLVANIA	A
th the Marylan or 28a-f show	ō	10a. State 10b. County 10c. City, Town or Location LAUREL 10c. City Limit 1 □Yes 2页5	
h the N or 28a-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
s 23a c		8805 ADMIRAL DRIVE 20708 UNITED STATES	_
be filed within 72 hours after death with the Maryland that Hygiene. do ther than "natural", or items 23a or 28a-f show event, the Model Eventher must be nothing at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 17. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, Specify Yes or Nofit Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or Nofit Yes, Specify Yes or Nofit Yes Yes Yes or Nofit Yes Yes Yes or Nofit Yes Yes Yes or Nofit Yes Yes Yes Yes or Yes or Yes Yes Yes Yes or Yes or Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	
"natu	etec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) II C COVERNMENT	
c vithii giene. gerthan	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 8 YEARS COMPUTER ENGINEER U.S. GOVERNMENT	
e d Hal	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARY MCCOVICK TOTH	
12 mg c 1	To	19a. Informant's Name/Relationship (Type. Print) MARY L. HELDER / SISTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 250 WARD AVE., AUDUBON, NEW JERSEY 08106	
		20a. Method of Disposition 1 X X urial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of HOLY CROSS CEM. 20b. Place of Disposition (Name of HOLY CROSS CEM. 10 NOVEMBER 10 20c. Location - City or Town, State YEADON, PA	
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility RUFFENACH FUNERAL HOME 2101 S. 21ST STREET, PHILADELPHIA, PA	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final	
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) At the solution of the soluti	
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of):	
cate be executed ohysician and the burial-transit	Examiner	cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):	
te be expression of the contract of the contra	dical E	d.	
entifica ing ph e as th	Medi	IF FEMALE:	
The law requires that the death certific that has been signed by the attending page 2 should be detached for use as the same of the same as the same a	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year Yea	
res that signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	WD
w requir	leted	24a. Was an 24b. Were autopsy findings availab	_
The larate has	Completed	autopsy prior to completion of cause o performed? death? 1 □ Yes 2 □ No	f
sician: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner? Hospital:	_
_ ≥ .⊻ ♡	7: To	27, Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	_
Attending Physician: If death. ector: After this certificially the funeral director.	ation	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	
To the Hospital or Attending Physicial To the Hospital or Attending Physicial Professor Affer the completely filled in by the funeral	Certification:	3 Suicide 4 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
e Hosp 24 hou e Fune iletely fi	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To th within To th	Me	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shirther 31. Date filed (Month, Day, Year) NOV 18 2010 29d. Date signed (Month, Day, Year) 32e. Registrar's Signature Aparth	
72B5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solventor Sylventor 3001 Hospital Drive Leverle nearlibed	
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
OHMH 17 Rev 1/2		HOT & O LUIU BEHAVIO G. LABOURE	_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 22 2010 Drew B. Taylor 9:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days Hours Min 1 □ M 2 👿 F (Month, Day, Year) 18 West Virginia 91 Director 227-60-1423 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗌 Yes 2 💢 No Virginia | Fairfax McLean 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6800 Fleetwood Road 22101 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. If Yes, Give White "natural", Specify: Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) filed within all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o William Guy Bechtol Myrtle Mary Kerns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith T. Judson/Daughter 9905 Mainsail Drive, Gaithersburg, MD 20879 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 Durial 2 Dremation 3 Removal from State ō Metropolitan Crematory 11/23/2010 injury Alexandria, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home MO1202 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
UNKNOWN Immediate Cause (Final ongestive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 as. attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ō Month Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy pertens 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Inpatient 2 XER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State

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only one)

31. Date filed (Month, Day, Year)

Chowde

CHOWDHURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29d. Date signed (Month, Day, Year)

11/22/10

5216 DINO DRIVE, BURTONSVILLE, MD 20866

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Teodors **Uldrikis** Physician/ Month 2010 Medical November 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Atlantic General Hospital Berlin Worcester **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Months Country Latvia 1 🕅 M 2 🗆 F Hours 1073071916 217-38-2755 94 Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 Boston Dr 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black White etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Completed by Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) maintenance supervisor Bd of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Teodors Uldrikis Kristina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lidija Uldrikis 124 Boston Dr. Berlin, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1st State Crematory 11/17/2010 Millsboro, DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-1 Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA funeral (Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 24 hours after death. Funeral Director; A 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 13 X Certifying Hurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signat nd title of certifie 29d. Date signed (Month, Day, Year) R 135131

Registrar DHMH 17 Rev 7/2009

State

Theodors

drikis,

9715 Healthway Dr,

address of person who completed cause of death (Item 23a) (Type, Print)

32. Régistrar's Signature

CRNP

Pennie Savage,

NOV 17

31. Date filed (Month, Day, Year)

November 15, 2010

21811

Berlin, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Nov. 10, 2010 Physician/ Valda Erdulfo \mathbf{F} 12:58pм Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1**₹** M 2 □ F Days Hours 1 1 1 5 7 1 9 2 4 214-06-1116 86 Bolivia Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a State be filed within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director Gaithersburg MD Montgomery 1 ☐ Yes 2 🖁 No 10f. Zip Code 20878 10e. Street and Number 10g. Citizen of What Country?
Bolivia 2 McDonald Chapel Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 🛎 Yes 2 □ No Specify Bolivian Specify: 3 Widowed 4 Divorced Year or Dates parmit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatur any injury or other traumatic event, the Medical.] 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sara V. Valda ္ဝ Luis Escobar 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolina Maria Cervantes/ 2 McDonald Chapel Court Gaithersburg, Md 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crem. 11/22/2010 Beltsville, Md Fune al Service L ce PHTTPPADESRINALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silyer Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ar est, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Perforation of Cecum disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by Ogilvie's syndrome 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Right acetabular fracture 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 1 No death? Diverticulosis 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 🖾 No Certificate: 28b. Time of 28d. Describe how injury occurred 11/9/19/2010 1 Natural
2 Accident 5 Pending unk. fell at home Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 McDonald Chape 1 Ct.Gaithersburg, Md 20878 determined Medical E Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis or examination allows investigation, in my spansor, search, search, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Date signed (Month, Day, Year) Nov. 19, 2010 29b. Signature and title 29c. License number

DHMH 17 Rev 7/2009

State

Registrar

30. Name and addr Eric

31. Date filed (Month, Day, Year

Park

NOV 22 2010

> D0060117 Nov.1

Ideause of death (Item 23a) (Type, Print)
8600 Old Georgetown Rd Bethesda, Md. 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 11/16/2010 Physician/ 2:00 A HILDA JACKSON VENEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cheverly Prince George's Prince George's Hospital Cente If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 07/10/1937 Country) Director 218-38-6186 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Prince George's MD Beltsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6118 Odell Road 20705 TISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) University of Maryland Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Doretha Jackson Green ukn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul A. Veney - son 6506 Otis Street, Cheverly, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial, 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Dogation 5 ☐ Other (Specify) vland Nat'1 Mem Pk | 11/22/10 Laurel, MD 21. Signatu Funeral Service Lio 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the diseas or complications that caused the death look of enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner PAILURE DECOMPETOTION Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes 2 7 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENEMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown has been signed by the property of the propert Division of Vital Becord 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy s certificate ha performed? Yes 2 No death? 2 🗌 No 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? within 24 hours after death.

To the Funeral Director. After this cal Hospital 2 No Other: ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide work?
1 Yes 2 No injury 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

Registrar DHMH 17 Rev 7/2009

State

only one)

31. Date filed (Month, Dar,

29b. Signature and title of certifier

address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

no ronc

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2010 :45 Α Winslow November Timothy James Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville 5 Bel Pre Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □XM 2 □ F Months Davs Hours Min. July 4. 1951 Massachusetts 59 030-42-2725 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department or Health and Mental Hygiene.
Important: If item 27 is marked other than "---" any injury or other than "---". 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20853 5 Bel Pre Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married þ Yes 2 XNo 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Federal Government Scientist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Winslow Miriam Timothy Cave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rockville, Maryland 20853 Bel Pre Court Katharine D. Egan/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/20/2010 Woodbine, Maryland 21. Signature of Funeral Service Lic Going Home Cremation Service P.O. Box 784 thomas Beverly L. Heckrotte, P.A. Clarksville, MD M00957 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ionsillar Cancor with disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Veal Other (specify) Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 ☐ No 3 ☐ Probably 4 H Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? after death.

Director: After this certificate 1 ☐ Yes 2 🕱No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury Matural 5 Pending Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 11-17-2010 D3T14Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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NOV 23

31. Date filed (Month, Day, Year)

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gistrar's Signatur

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Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. amend #8 Sexte 54 Mary and 4/15/dar meth of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Nov. 13 pay Physician/ 2010 Marlene Williams 11:02 Jane Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Montgomery General Hospital Olney If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Min Months Days Hours 162-26-5098 7 7Yrs Director 1933 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State **Funeral Director** 1 Yes 2X No MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2901 S. 20906 Leisure World Blvd. #329 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Howard R. Lease Anna E. Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oxfordshire Terrace, Olney, 20832 Robert A. Williams/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Nov. 1 Burial 2 🛣 Cremation 3 D Removal from State Metropolitan Crematory 2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
00 University Blvd. W, Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between shock, or heart failure. List only one cause Onset and Death 5 UDDEN Immediate Cause (Final disease or condition ROSCLEROTIC ARDIOVASCULAR Physician/ Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a fer det.th.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial trivial. t usit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months Pregnant at time of death 5 Other (specify) g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 \sum No 26. Place of Death (Check only one) Be Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar (Check

only one 29b. Signature

31. Date filed (Month, Day, Year)

o completed cause of death (Item 23a) (Type, Print) 18101

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

YOVEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38846 State of Maryland / Department of Health and Mental Hygiene ? State
Registra MEND#5perFH, 11/22/10, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Margaret S. Weiss 2010 11:50 PM <u>November</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Shady Grove Nursing Home and Rehab. Montgomery 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country)
York **Funeral** (Month, Day, Year) Min 1 M 2 X Months Days Hours 86 Director New Nov Usual Residence of Decede ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Rockville MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 20852 9701 Medical Center Drive Room 101 USA "natural", or items 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 □ Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Pasternak Morris Siegal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7313 Black Road, Thurmont, Maryland 21788 Joel Weiss/Son 20b. Place of Disposition (Name of cemetery, crematory or other place Judean Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/16/2010 | Olney, Maryland 22. Name and Address of FacilitEdward Sagel Funeral Direction, 21. Signature of Funeral Service License ul Cerrell hut MO(597 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph sician/ Cardio Pulmonary Arrest disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Life Long Diabetes Mellitus Sequentially list conditions, it may leading to mind district cause. Enter Underlying Examine Due to for as a consequence of as the burial-transit The law requires that the death certificate be executed Cause (Disease or liniury Hypertension and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical <u>Atrial Fibrilation</u> Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?
1 ☐ Yes 2 🗓 No Month Day Year Pregnant at time of death 1 Yes 2 D ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det þ 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No 1 🗌 Yes 2 🗆 No certificate 24 hours a er dezth.
Funeral Director. After this certific eted filled by the funeral director. r Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes မ 2 TNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 K Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a, Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending 1 X Natural Investigation 2 Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Hurse Practioner. To the both of my knowledge, death of dist the time date and place a To the within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number November 15, 2010 LD D0067092 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weihan Wang, MD, 15245 Shady Grove Road, Suite 130, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 3 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ver1 Dumas November 2010 6:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Friends Nursing Home Montgomery Sandy Spring 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Davs Hours Min (Month, Day, Year Country) Director 491-09-8021 96 Tune Kansas Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral er than "natural", or items 23 the Medical Examiner must I 20906 3310 N. Leisure World Blvd. Apt 805 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No WW II
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify White Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygien Telephone General Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Verl Ward traumatic the stand 2 should be thent of Health and Mertant of Health and Mertant If item 27 is mark Maude Dumas 19a. Informant's Name/Relationship (Type, Print) Verl Randal Ward / Son permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 16,2010 Alexandria, VA 22. Name and Address of Facility
DeVol Funeral Home, 10
Gaithersburg, Signature of Funeral Seg ice Licenses East Deer Park Drive, MD 20877 M01117 1 RACY. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Cancer of Esophagus Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cancer of Liver Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and dbe detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypothyroidism 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? eral Director: After this certificate I filled in by the funeral director, pag 2 X No 1 Yes 2 No Yes 25. Was case referred to medica Certificate; To Be 26. Place of Death (Check only one) examiner? 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 💢 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year

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State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Merlyn Vemury, M.D.,

31. Date filed (Month, Day, Year)

D35791

9801 Georgia Avenue, Silver Spring, MD 20902

November 16, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rosalind Light Williams Month Physician/ 2:19 Medical November 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Manor Care Bethesda Bethesda If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Country Director 84 156-18-9495 08/25/1926 Jersey New Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at ا and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural". or items 29a مه 1900 دادمات 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20011 3800 Argyle Terrace NW 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Long Term Care Elementary/Seconday (0-12) College (1-4 or 5+) Facility Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Berna R. Rahb Theodore B. Light 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7702 Hamilton Spring Rd. Bethesda, MD 20817 19a. Informant's Name/Relationship (Type, Print) Karen L. Williams / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of I Important: If it 11/19/2010 1 Burial 2 Cremation 3 Removal from State Silver Spring, MD Gate of Heaven Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ LEUKEMIA HRONCE LYMPHOCYTIC disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to for seig consugueries of if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available 24a. Was an the Hospital or Attending Physician: The law autopsy performed Yes 2 prior to completion of cause of death? 1 Yes 2 Do 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending To the Hospital or Attendir

within 24 hours after death.

To the Funeral Director. Af
completed filled in by the fu death. 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) la Beno, uns

State Registrar

31. Date filed (Month, Day, Year) 2. Registrar's Signature NOV 18 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao MD 10110 Molecular Dr. #206 Rockville, MD 20850

00057124

11/11/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 - State Certificate of Dea	LII	giene 2010 38849
1. Decedent's Name (First, Middle, Last)	2. Date of De	ath 3. Time of Death
Physician/ Medical Douglas Martin Wright	Nownth 1	6, ^D 2010 Year 2:41 A M
Examiner 4a. Facility Name (if not institution, give street and number) 11726 Riverview Dr. 4b. City, Town, or Local Berlin	ation of Death	4c. County of Death Worcester
	Jnder 24 Hrs. 8. Date of Bir burs Min. j (140 pth. 12	9. Birthplace (State or Foreign Country) MD
Laural Presidence of Decedent		
De to to to to to to to to to to to to to		10d. Inside City Limits 1 ☐ Yes 2點 No
MD Worcester Berlin 10f. Zip Code		10g. Citizen of What Country?
we get to be a state and Number a		USA
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani	ic Origin? (Specify Yes or No-	14. Race - American Indian,
ap	exican, Puerto Rican, etc.)	Black, White, etc. white Specify:
3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life DO NOT use retired) 17 College (1-4 or 5+) 18 Siness Owner		
15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Specify only highest grade completed) (Specify only highest grade completed)		16b. Kind of Business Industry Furniture Repair
The very married 2 to married 2		furniture kepair
7 Part of the second of the se	Mother's Name (First, Middle,	
De pal pal pal pal pal pal pal pal pal pal	Alfreda Dougl	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No. 2 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Number or Rural Route Number ${ m Dr. \ Berlin.}$	nr, City or Town, State, Zip Code) MD 21811
	Date	20c. Location - City or Town, State
1 □ Burial 名 Cremation 3 □ Removal from State cemetery, crematory or other place) 日 学 音音 と 4 □ Donation 5 □ Other (Specify) First State Crem.	11-17-10	Millsboro, DE
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign sure of Funers Service License 22. Name and Address of 1.08 Wii 11 jam S	Facility Burbage F	uneral Home
1. Man Joseph L	Street Berlin,	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause of each line.		
Immedical Medical Examiner Medical Examiner Medical Examiner	OCHWANNOM.	14
Examiner Due to (or as a consequence of): Examiner	NGE	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilinjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		
Cause (Disease or linjury that initiated events resulting in death) Last Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a consequence of): d. Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy		
D		23d. Date of delivery
per composed and partial that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Ca		Month Day Year
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I. 23e Did t	robacco use contribute to the cause of death?
in the past 12 months? 1	1 🗆	
The law requires rate has been signage 2 should be completed	24a. Was	
Set of the set of the	auto	psy prior to completion of cause of death? 2 No 1 Yes 2 No
The tent of the te	of Death (Check only one)	Z No.
Control of the cont	☐ Nursing Home 5 🗷 Res	dence 6 Other (Specify)
So to the property of the prop	28d. Describe	how injury occurred
28a. Date of Injury - At home, farm, street, factory, office building, etc. (Specify) 28b. Injury at work? 28c. Injury at work? 2		Street and Number or Rural Route Number,
26. Place of linjury at work? 1	City or To	wn, State)
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, determined to the control of the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation.	eath occurred at the time, date	and place, and due to the cause(s) and manner stated.
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time 29b. Signature and title of certifier 29c. License nun	ne, date and place, and due to t	he cause(s) and manner as stated.
10 puccas De 1046.	25.7	11:16.2010
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 271 10 EMW (N STATE NAME) (TSU (N) 06.	em lity Be	29d. Date signed (Month, Day, Year) 11: 16 2010 VD (Sexum, 4002181)
State Registrar 31. Date filed (Month, Day, Year) 12. Tegistrar's Signature 13. Date filed (Month, Day, Year) 32. Tegistrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dorothy Loats Walsh Nov. 2010 8:55a 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Long View Nursing Home Carroll Manchester If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 87 Yrs. 219-18-0313 17 1922 Dec MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐ No MD Carroll Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3300 Carrollton Road 21074 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2☐ Married 1 ☐ Yes 2 ☑ No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence William Loats Treva Lippy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ralph S. Walsh, husband 3300 Carrollton Rd., Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Cemetery 11/13/2010 Hamsptead, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility M00741 Eline Funeral Home pande 21074 St. Hampstead, Md. Main 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown eath? Inknown

Physician /Medical **Examiner**

permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natum any injury or other traumatic event, the Medical once.

Physician

Examiner

Funeral

Director

28a-f show

"natural", or items 23a or 28a-f shov edical Exaπiner must be notified at

Director

Funeral

þ

Completed

Be

၉

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and in by the

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Be Completed Certification: To

Medical

State Registrar

Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 5 ☐ Pending investigation

2 Accident

29a. Certifier

art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
	1 □ Yes 2	No 3 Probably 4 □Unknown
	24a. Was an autopsy performed? 1∐ Yes 2 🕅 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No

				24a. Was an autopsy performed? 1 Yes 2 X N	24b. Were autops prior to complete death?
			26. Place of Death (C	heck only one)	
Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Home	5 Residence	6 □Other (Specify)

28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

and manner stated.

1 🗡 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

6 Could not be

29c. License number

29d. Date signed (Month, Day, Year)

+5 WIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2010 Year Physician/ November 4:05 A ^M Virginia Queba Wheeler Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Lutheran Village Healthcare Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye ADRIL 19, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1924 MD **Director** 86 220-12-7364 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State Director 1 XYes 2 No Westminster MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 23a Funeral 21158 USA Examiner must 300 St. Luke Circle items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.; Black, White, etc. 6 <u>8</u> 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emory G. Wilhelm Addie Beulah Hundertmark 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1429 Allen Way, Westminster, MD 21157 Warren Wheeler/son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Upperco, MD 11/12/2010 Paul Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Onset and Death Immediate Cause (Final Physician/ NEUMONIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Exami -tran Due to (or as a consequence of) the burialattending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions, contributing to death but not resulting in the Inderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrillation, Hypertension 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CA1255100 autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at wo<u>rk</u>? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 701860 NJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) layless Way # 114, Ellersburg, md 21784 10 WL James

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2010 10:02 a ^M Gloria Weisbrot November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery Hospice Casey House Rockville . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Months Days Hours Min (Month, Day, Y New Jersey Director 85 148-12-4604 Aug Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director Silver Spring 1 🔀 Yes 2 🗌 No Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20906 within 72 hours after death with 3005 South Leisure World Blvd #214 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: nan "natural", Medical Exar 3X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Education Teacher/Librarian traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | Lillian Lewis Ratiner Harry Friedlander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. 20852 11008 Roundtable Ct, Rockville, Maryland Susan Stone, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
acific View
Memorial Park 1 🔀 Burial 2 🗌 Cremation 3 💭 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/16/2010 Corona Del Mar, Funeral Sauce Licenses 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. MO1255 20852 Rockville Pike, Rockville, Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ End Stage Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Intestinal Obstruction this certificate has ral director, page 2 autopsy performe 1 Tyes 2 No 1 Yes 2 X No 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 **X**No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 4 Nursing Home 5 Residence 6X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie

within 2 To the I the 0

Registrar

State

(Check

only one)

29b. Signature and tifle of certifie

31. Date filed (Month, Day, Year)

Debrah Miller CRNP,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sid

CRNI

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

R143201

20855

29c, License number

6001 Muncaster Mill Road, Rockville, Maryland

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 15. Physician/ 2010^{Day} James Allen Wilson 17:00P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 8. Date of Birth (Month, Day, Year) July 6, 1948 If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F 215 48 7314 62 Winchester, VA Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified Temple Hills MD Prince George's 1 ☐ Yes 2√√ No 0 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral 3205 Carlton Ave 20748 United States items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married "natural", or þ Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Specify: white Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Repair Tech Heating/Air Conditioning Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ be f James Wilson Frances Miller . 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 3205 Carlton Ave, Temple Hills, MD 20748 Jacqueline L. Wilson (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Nov 19, 2010 Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature of Funeral Service Licensee Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequer Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? been signed by the atte should be detached for Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referre 26. Place of Death (Check only one) examiner's Other: 1 Tes 1 Inpatient 2 NER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending Injury 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nerse Practioner: To the best of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month)

State

Registrar

MAST

31. Date filed (Month, Day, Year)

NOV

19

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2010

32. registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:00p M Donald M. Wilson November 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney Montgomery Montgomery General Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Davs Hours (Month, Day, 08/19/ Connecticut 527-46-2745 Director Usual Residence of Decedent 28a-f show 10a. State 10b County 10d. Inside City Limits 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland Director Ashton 1 Yes 2 No Montgomery Maryland 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral U.S.A. 20861 1325 Patuxent Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Year or Dates "natural", White Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government Administrator Small Business Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ Helen Peck Merrill A. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1325 Patuxent Drive. Ashton. Maryland 20861 Dorothy K. Wilson - Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 🗆 Burial 2 🛴 Cremation 3 🗆 Removal from State Lincoln Crematory 11/26/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee

ANNEW WILL WILL Nor 11800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiorespiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Metastatic Biliary Pancreatic Cancer Unknown Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and I-transit requires that the death certificate be exercised Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 L No ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No Yes 2 X No Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tyes 1 X Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work X Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

10

Registrar DHMH 17 Rev 7/2009

State

29a. Certifier

(Check

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Sound

COUNTY SARKAR, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONTGOMERY

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0070749

GENERAL HOSPITAL, OLNEY, MD

29d. Date signed (Month, Day, Year,

20

12010

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland	•	rtment of F tificate of D		and M	, ,	9	nii	1 38855
			Registrar 1. Decedent's Name (First, Middle, Last)			0071	incate or E	Catri		2. Date of Dea	Reg. No. 🦾 th	. 0 1 0	3. Time of Death
	Physicia		Selma Suzanne Ya	tes						Month NOVEMBE	R 20	Year 2010	12:16A.M.
~ ~	Medic Examin		4a. Facility Name (if not institution, give str			i	4b. City, Town, or	Location of		MONT PROF	,	ounty of Dear	
مسد			Reeders Memorial H	ome			Boonsbo	ro			Was	hingto	on
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. las		If Under 1 Year Months Days	If Under Hours		8. Date of Birth (Month, Day	Year)	Co	thplace (State or Foreign untry)
	Director		215-26-8696 Usual Residence of Decedent	2 34.	79	Yrs.				6/9/193	1	Mar	yländ
	and show lat	ō	10a. State 10b. County		10c. City,	Town or Loca	ation						10d. Inside City Limits
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	the la or 2 oe no	Ö	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Co	ountry?
	n with	Funeral Director	11305 Manse Rd.				21740				U.S.	Α.	
	death r item iner n	Fui	Ti mana status	 Was Decedent Every Armed Forces 		13. W If	as Decedent of Hi Yes, specify Cuba	spanic Oriç n, Mexican	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	14.	Race - Ame	erican Indian, e. etc.
50	after al", o	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Year or Dates.	No	1	☐ Yes 2 No	Specify:			Sp	ecify: Wh:	,
9500-612	hours natura ical E	lete	15. Decedent's Educ	cation	-		ent's Usual Occupa				16b. Kind	of Business	
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7	with gient her th t, the	Ö	12			Perso	nnel Ass	istan	t		News	paper	
	e filed ntal H ed otl	To Be	17. Father's Name (First, Middle, Last)							(First, Middle, I	Maiden Sur	name)	
Maryland	d Mer d Mer mark natic		Braden Ellsworth S					Hild		dwards			
<u>≅</u>	2 sho th and 27 is I		19a. Informant's Name/Relationship (Type			`	g Address <i>(Street a</i> A Abbey				-		•
ā,	Head Head Head Head Other		Kathy Yates / Daug 20a. Method of Disposition		20b. Pla	ce of Dispos	ition (Name of			ate			Town, State
Ē	age lent or		1 ABurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	emoval from State			atory or other plac n Cemete		1/23	/10	Hager	etom	Maryland
saitimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Cice (see	?	TICO		Name and Addres						
מ			1		\sim								ryland 21740
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused cause on each line.	the death.	Do not enter	the mode of dying	g, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
÷ .	Physician/		Immediate Cause (Final disease or condition	MUTASI	MIC	ے گا	MUAN	CANE	EL				Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	,	nce of):	MENTA MENTA						
		er	Sequentiary list conditions,	Due to (or as a	(CCT)		am on The					_	WOUNTS.
	ted I Insit	amir	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	(,							
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	that initiated events c. resulting in death) Last	Due to (or as a	conseque	nce of):							
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200	tificating phase as the	Φ	IF FEMALE:										
POX	ith ce	ian/	in the past 12 months?	 c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 	Petal o	death 3	Ectopic pregnanc Other (specify)	у			230	d. Date of de Month	livery Day Year
ñ	the a	Physician/M	1 Yes 2 No 9 Unknown	9 Unknown	time of dea	atii 5 🗆	Other (specify)						
5	that the	by Pt	Part II. Other significant conditions cont	ributing to death bu	t not result	ting in the un	derlying cause giv	en in Part I	1.	23e. Did to	bacco use	contribute to	the cause of death?
Z,	uires l n sigr	ed b								1 🗆 Y	'es 2 □ I	No 3 □ P	robably 4 Dunknown
Ö	w req	plet								24a. Was a autop			topsy findings available completion of cause of
vital Records,	The la	Completed								perfor	med? 2 D No	death?	s 2 No
<u> </u>	sian:] ertifica ctor, p	Be	25. Was case referred to medical examiner?					ace of Deat	th (Check		(
5	hysic this ca	မ	1 LI Yes 2 VI No	spital:				4 X 2 Nu		ne 5 🗆 Resid			eify)
n or	ding F h. After funera	Certificate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day,	Year)	8b. Time of injury	28c. Injury work M 1 \square	rat ? Yes 2 🗍	- 1	8d. Describe ho	ow injury oc	curred	
<u> S</u>	Attender deat ctor:	rtifi	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injur	y - At hom	ie, farm, stree		165 2 🗆	-	8f. Location (S	treet and N	umber or Ru	ral Route Number,
DIVISION	al or / s after I Dire		4 ☐ Homicide determined	building, etc.	(Specify)					City or Town			
_	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physici Check 2 Medical Examine										ated. cause(s) and manner stated.
	the H hin 24 the F mplete	Me	only one) 3 Certifying Nurse	Practioner: To the b			eath occurred at the	time, date		, and due to the	cause(s) ar	nd manner as	stated.
	5 vit		29b. Signature and title of certifier)			29c. License		7 :	2	. 1	igned (Monti	h, Day, Year)
			y O	redu /	=4h (l4 2	10 a) /Time = 0	1 0	465	6		No	V di	0, 2010.
51	6-2		30. Name and address of person who com DR. GHAZALA OADIR.				, BOONSB	ORO -	MARY	I AND 21	713	301-4	32-8470
) I	Stat	е	31. Date filed (Month, Day, Year)		's Signatur		, 500,100	5110 9					
	Registra	ır	NUV & J ZUF	La patrice	الم مه	7.	Sec.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ΪŎ, 2010 George William Ziegler, Sr. 11:54 AM November Medica 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Carroll Westminster 8. Date of Birth (Month, Day, Sept. 2 9. Birthplace (State or Foreign Country)
MD Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Hours **M** 2 □ F Director 218-14-8241 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director notified 1 √xYes 2 □ No MD Carroll Westminster ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be r 23a Funeral 3 Fox Meadow Garth Examiner must 21157 USA items 12. Was Decedent Ever in U.S. Armed Forces?
***XX** Yes 2 \sum No 19 If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1941 "natural", or ò 1 Never Married XX Married Maryland 21215-0036 1 ☐ Yes 2 XXIIo Specify. 3 Divorced 4 Divorced Specify 1945 Completed White than "natur he Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

27 is marked other than ar traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Sales Representative/Manager U.S. Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked or any injury or other traumatic even once. Clarence William Ziegler Ellen Marie Mullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Ziegler/wife 3 Fox Meadow Garth, Westminster, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 11/19/2010 Carrison Forest Vet. Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA Signature of Funeral Service Lig 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a co **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Dav Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 2 🗆 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury injury Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

29b. Signature and title of certifier

Name and address of p

DHMH 17 Rev 7/2009

rson who complete cause of death (Item 23a) (Type, Print)

55 South

29d. Date signed (Month, Day, Year)

(NOOTHIUSTON, NO 2157)

7010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3885 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2010 Dec. 8:40AM M Ellen Louise Aspiras Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4004 London Terr. Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F 60 Months Days Hours (Month, Day, Year) 06/16/1950 Director 213-56-0151 Usual Residence of Decedent or 28a-f show notified at filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director St. Michaels MD Talbot 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö ,s 23a oı (must b 10g. Citizen of What Country? Funeral 21663 108 N. Talbott St. USA ural", or items a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural", If Yes, Give 3 - Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed 4 Shop Keeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Edward Turner Kathryn Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Madalena Aspiras/Daughter 2604 Shanandale Dr. Silver Spring, MD 20904 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. 8te ☐ Burial 2. Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 2010 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of FacilitRapp Funeral & Cremation Services MO1585 Kebecca 933 Gist Ave. Silver Spring, MD 20910 Ackemon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death
Month Physician/ Hepatic Failure Medical resulting in death) Due to (or as a consequence of Examiner 3 Years Metastatic Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of 19 Years Primary Breast Cancer Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 2 1 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 5 Pending work? 1 \sum Yes 2 \sum No 1 Natural 2 Accident 3 Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral C completed filled 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year)

DEC 1 0 2010 Registrar

Dr. Rebecca Kaltman 6410 Rockledge Dr. Carolyn B. Hendricks Suite 506 Bethesda, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD038523

Dec. 7, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Estelle Ashe December 3:15 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1699 Poles Rd. Baltimore Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Davs Hours 246 28 8230 North Carolina Director 83 1927 Usual Residence of Decedent show 10a. State 10b. County at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits must be notified Direct 28a-f Maryland Baltimore 1 ☐ Yes 2X No Essex 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1699 Poles Rd. 21221 LISA ral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 🔀 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural" 3 X Widowed 4 ☐ Divorced Completed Year or Dates al Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service 11 Cashier other traumatic event. Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Mannie Sturdivant Bessie Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly I. Proffitt (Niece) 3403 Mueller Street Baltimore, Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gardens Of Faith Cemetery 12/11/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Supplied of Fundal Space Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex Maryland Part 1. Priter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ di ase or condition sulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Directo for as a consequence of, cause. Enter Underlying Cause (Disease or iinjury and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year 4 Pregnant a 9 Unknown Day Pregnant at time of death Yes 2 X No the 9 Unknown P.O. | ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 3 ☐ Probably 4 ☐ Unknown should k Completed 1 Yes No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas page 2 autopsy performed? certificate | 1 Yes 2 No Yes 2 V N Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🙀 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) this After this funeral of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending work?
1 Yes 2 No 1 🛚 Natural injury 5 Pending death. within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of pers in woo completed cause of death (Item 23a) (Type, Print) Huzefa Bahrai, D.O., 9110 Philadelphia Rd., Ste. 314, Balto., Md. 21237

Registrar

State

32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 8,2010 2:00 Anna H. Ardos Ам 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Morningside House Parkville Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Dec. 19, 1915 1 M 2 X F 186-10-1141 94 Pennsylvania Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Harford Road 21234 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 2 XNo If Yes, Give Year or Dates 1 Yes 2 XNo Specify: white Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Textile Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Polansky Martha Hamerski 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Galileo Drive-Cranbury, New Jersey 08512 Beverly Ann Fredericks-20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Summit, Pennsylvania St.John Byzantine Cem. Dec.13,2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 onder 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2007 Immediate Cause (Final Atrial Fibrillation disease or condition resulting in death) Due to (or as a consequence of): Congestive Heart Failure 2007 Due to (or as a consequence of): Aortic Stenosis 2007 Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Month 1 Yes 20 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

h sician/ Medical **Examiner**

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attending physician for use as the buria

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After t

within 24 hours after death

To the Funeral Director: A
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and

or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

or 28a-f show notified at

ö

Hygiene. other than "natural", or items 23a or ent, the Medical Examiner must be

1 and 2 should be filed with of Health and Mental Hygien item 27 is marked other the other traumatic event, the

permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once.

Director

Funeral

by

Completed

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Examine

Physician/Medical

Completed by

Medical Certificate: To Be

IF FEMALE:

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Equantiary list outside its, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

> 23e. Did tobacco use contribute to the cause of death? Esophageal stricture, Hypertension, 1 ☐ Yes 2 🖁 No 3 ☐ Probably 4 ☐ Unknown Giant Cell Arteritis, Recurrent DVT

		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No									
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? X 1 \sum Yes 2 \sum No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho	Assiste									
27. Manner of Death 1 🔏 Natural 5 🗆 Pending 2 🔲 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred									
3 LJ Suicide 6 LJ Could not be 4 LD Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier Certifying Phys	sician: To the best of my knowledge, death occured at the time, date and place, an	d due to the cause(s) and manner as stated.									

29a. Certifier (Check (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	n, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner state
9b. Signature and title of certifier	29c. License number D22472MD	29d. Date signed (Month, Day, Year) December 9, 2010

Host and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch Raven Blvd, Baltimore, MD 21239 Dr. Peter Holt, MD 31. Date filed (Month, Day, Year)

State Registrar

DEC 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of N	Maryland /	-	artmeni rtificate			and M		giene Reg. No.	010	
			Decedent's Name (First, Middle, La	ist)							2. Date of Dea	ath		3. Time of Death
н	Physici		James Bell								Month Novembe	Day	, 2010	2:40 AMM
mar.	/Medid Examir		4a. Facility Name (If not institution, gir	ve street and number	er)		4b. City,	Town, or	Location	of Death	110.01.0		County of Deat	
	LXaIIII	lei	Riverview Reh]	Esse	X				Baltin	nore
	Funeral		5. Social Security Number 6.	Sex 7.	Age (In yrs. last b	irthday)	If Under		If Under		8. Date of Birt	h Vaarl	9. Birt	hplace (State or Foreign
и	Director		260-56-5484	1 🔀 M 2□ F	71	Yrs.	Months	Days	Hours	Min.	Nov 3,	"1939	Geo	rgia
	pr ,		Usual Residence of Decedent								`			
	show	, <u> </u>	10a. State 10b. County		10c. City, Tov	vn or Lo	cation							10d. Inside City Limits
	8a-f	Scto	MD Balti	more		E	ssex							1 □ Yes 2 √ No
	or 2	Dire	10e. Street and Number				10f. Zip		1001			10g. Citiz	en of What Co	untry?
	should be filed within 72 hours after death with the Maryland not Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Marilent Eventual to motified at	by Funeral Director	One Eastern Blvd						1221				USA	
	er de	nu.	11. Marital Status	12. Was Deceder Armed Force	s?	13.	Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Ori n, Mexicar	gin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	. 1	 Race - Ame Black, White 	
36	s aft	χF	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 ⊈ If Yes, Give Year or Date:			1 □ Yes 2	₹ No	Specify:				Specify: bla	.ck
8	hour tural	ba	15. Decedent's E			2 Dece	dent's Usua	I Occup	ation			16h Kin	d of Business/	Industry
21215-0036	in 72 "na Pafic	olet	(Specify only highest gr	ade completed)	1	(Give	kind of wor DO NOT us	k done c	lurina mos	t of work	ing	100. 1011	ia or business/	industry
212	with jiene r thau	Completed	Elementary/Secondary (0-12) Q	College (1-4d	or 5+)	1 01	orer							
p	filed I Hyg other ent,	Be C	17. Father's Name (First, Middle, Las				DULEL		18. Mothe	er's Name	e (First, Middle,		stauran Surname)	its
Maryland	lid be lenta ked ic ev	To B	James Benjamin Bell Paulin							ine Bro	ne Brown			
ary	should be filed withi and Mental Hygiene. is marked other thar aumatic event, tre. M	-	19a. Informant's Name/Relationship		19	b. Mailir	ng Address	(Street			al Route Numbe		Town, State,	Zip Code)
	1 and 2 Health a em 27 is	- 5	Pauline Bell-Bro	own/siste	r	2302	Tudo	r Di	cive .	Augu	sta, GA	309	906	
ore	of He item		20a. Method of Disposition	7	20b. Place						Date		cation - City or	Town, State
altimore,	Pages nent of hant I fite		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Speci		te	,		•						
alt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marian Examinator and once.		21. Signature of Funeral Service Lice	nsee to D	Jodton	22	Name and	d Addres	s of Facilit	y Boar	4 655 W	Ra	ltimore	Street
Ш	8 9 E 8 9		Manager S.	Wanes Dx	rector		Raltin		-	212		• Da.	LETMOTE	Bereet
			23a. Par 1. Enter the discase, or consho k, or heart failure. List only	cations that caus	sed the death. Do						-	rest,		Approximate interval Between
CQ.	Physician		Immediate use (Final disease or condition		un man - wewer									Onset and Death
	/Medical		resulting in death)		n consequence	e of):								WEGENS
	Examiner													
	73 #	Je.	Sequentially list conditions, if any, leading to immediate cluss. E. t. of Underlying Cause (Disease or injury											
	cate be executed physician and the burial-transit	Examiner	that initiated events	C	C									
o,	e exe ian al ırial-t	Ж	resulting in death) Last	Due to (or	as a consequence	of):								
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9		Med	IF FEMALE:										ļ	
Вох	eath certific attending p for use as	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live birtl	me of pregnancy h 2 🗆 Fetal deat	th 3[Ectopic pr	regnancy	/			2	3d. Date of de	
0	e dea	sici	1 □Yes 2 ⊡rNo		t at time of death		Other (sp						Month	Day Year
<u>P</u> .	Physician: The law requires that the death certificate has been signed by the attending rail director, page 2 should be detached for use as	Physician/Me	9 Unknown								On Dista			the cause of death?
ŝ,	ires the signe		Part II. Other significant conditions	is due	i but not resulting	in the u	ndenying ca	tuse give	m m Panti					_
Records,	w requir s been s should	Completed by	70-1-2000		1						1 1	′es 2□] NO 2 P	robably 4 A Waknown
ec	e law has b	pldu	Cleanic plants	بالعصينين	weren at		<u>ب</u>				24a. Was autop	sy	prior to	topsy findings available completion of cause of
<u>—</u>	: The l	S	dencitu alce	er,							1 □Yes	rmed? 2 400	death? 1 ☐ Yes	2 □ No
Vital	nysician: Than sertificate director, pag	Be	25. Was case referred to medical examiner?	I I ia - I				1011		of Deat	h (Check only o	ne)		
of	Physic ruthis crall dire	ဂ္	1 ☐ Yes 2 ☐ No		atient 2 ER/C				4 LLIN		me 5 Resid			cify)
Ē	ding F. After funera	ino ino	27. Manner of Death 1 ☐ Natural 5 ☐ Pending		njury 28b. <i>Day, Year)</i> 28b.	Time of Injury		Bc. Injury Work			28d. Describe h	now injury	occurred	
Sic	Attendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2□		0001			
Division	or Al	Certification: To	4 ☐ Homicide determined	building,	Injury - At home, f etc. (Specify)	arm, str	eet, ractory,	опісе			City or Tou	otreet and vn, State)	l Number or Ri	ural Route Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical		hysician: To the be miner: On the basi and manner	s of examination a									
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner	siaicu.		290	. License	number		T	29d. Date	signed (Mont	h, Day, Year)
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7			30. Name and address of person who	completed cause of	of death /Itam 00-1	(T::::::		~(7		1				
		1		D 7310				# S	8.0	CACE 1	Surg 1 8		20116	

State Registrar parke

10-09023 Jack Bartell Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day November 24, 2010 **Medical Examiner** 1038 hrs Jack Bartell 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore 1820 Spence Street Apt, 212 5. Social Security Number 1 6. Sex If Under 1 Year 7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** New Days Director 1X M 2 F 48 Apr 25, 1962 Jersev Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d Inside City Limits s 23a or 28a-f show a notified at once. 1 Yes 2 No more, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
ant: If item 27 is anarked other than "natural", or items 23a or 28a-f sho rother traumatic event, the Medical Examiner must be notified at once. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1820 Spence Street #212 21230 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Yes 2 X No 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: white ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Completed Elementary/Secondary (0-12) College (1-4 or 5+) bean bag filler 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) unk Be <u>Joyce Hope Bartell</u> ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 773 W. Cross Street Baltimore, MD <u> William Katzenberg/uncle</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Itimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: 9 21. Signature of Euneral Service Licensee ROTTal 0 State Anatomy Board 655 W. Baltimore Street ctor Baltimore. MD 21201 Approximate Interval **Physician** Rart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lure. List only one cause on each line. Between Onset and Madical Immediate Cause (Final disease Alcoholism Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial - transi The law requires that the death certificate be executed Physician/Medical 23a,pt.II,27 per me g9ll 1-20-11 vt X UNPENDED AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Cocaine Use Completed Records, certificate has been s rector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital å Other Nursing Home 5 Residence 6 Other: Scene Inpatient 2 ER/Outpatient 3 DOA After this 1 V Yes No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No the Funeral Director: Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Gal 2 📝 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 25, 2010 While 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month) Physician/ Day 320 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltumor tomore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth **Funeral** Days Hours Min. 1 □ M 2 🗓 F 05\\\\03\\\\\1922 88 **Director** 214-16-8924 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Joppa 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 524 B Riviera Drive 21085 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Force: If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ☐ Yes 2 X No Š 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates. Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Distilery Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis Martini Catherine Heitzenroder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLayton F. Bollack, Jr. (Son) 526 C Riviera Drive Joppa MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Mem. Gar. 09-10-2010 | Fallston, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee nem Inc 610 W. MacPHail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consuluence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (was a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown g Unknown vision of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ☐ Yes 2 N 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Zertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) DEC 10 2010

32. Registras's Sign

	-	ľ	1 - For State Registrar	•	rtificate of E		Re	eg. No. 201	0 3886	5	
	Physicia	an	1. Decedent's Name (First, Middle, Last) ZELLA	B	ARNES		2. Date of Death Month DECEMA	Day V	3. Time of Death	A	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	, O,	4b. City, Town, or I	Location of Death	DECEM	4c. County of		_	
	LXaiiiii	CI	NORTHWEST HOSPITAL		PANDA	LISTOWN	t	BALT	MORE		
١	Funeral Director		219-20-1013	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05-11-	Year) 3 2 9	O. Birthplace (State or Foreig Country)	дn	
	ryland how at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	n or Lo	cation		·		10d. Inside City Limits		
	e Ma Ba-f s	Director	MD NA Balt	im					1 X Yes 2 □ No	٥	
	vith th	Dire	10e. Street and Number		10f. Zip Code	_	10	0g. Citizen of Wha	at Country?		
	s 23a	eral	6607 Windsor Mill Road 11 Marital Status 12. Was Decedent Ever In U.S.	110	2120		poits Voc or No	USA	American Indian,	_	
2-0036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, if a fired Evaminer must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cubar 1 □ Yes ② X\(\)\(\)\(\)\(\)\(\)	Specify:	Rican, etc.)	Black, \	^{White, etc.} Africar American	1	
ה ה	72 ho natur fical	eted	15. Decedent's Education 16a. (Specify only highest grade completed)	. Dece	dent's Usual Occupa	tion	70	16b. Kind of Busin	ness/Industry	_	
7 7	filed within Hygiene. Other than "sent, Ire Mec	Completed	Flamentary/Secondary (0.12) College (1.4or 5.)		kind of work done do DO NOT use retired) Stic	aing most of working		Homes			
and	al Hy d other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name					
ya	2 should be and Mental is marked or raumatic ev	은	David E. Burley			Ruth		ower			
Mar	12 shoh and hand 7 is m	1 8			ng Address (Street a					7	
a,	1 and Health em 27							LLLINOL6 20c. Location - Cit	e, MD 21207	_	
Банттог	permit. Pages 1 and 2 should I Department of Health and Men Important: If item 27 is marke, any Injury or other traumatic once.	7/	4 Donation 5 Other (Specify)	iso	sition (Name of natory or other place n Forest	: 12-1	6-10	Owings	Mills, MD		
a D	permi Depar Impor any Ir once.	0	21. Signature of Funeral Service Licensee						re,MD 21217	7	
, .	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition					est,	Approximate Interval Between Onset and Death		
	/Medical Examiner		disease or condition resulting in death) a	_	ACGUIRE	D PHEOL	MONIA			_	
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	ecuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence.								
00/00	rtificate be executed ng physician and as the burial-transit										
-	ng ph	Medical	IF FEMALE:							_	
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<u>ง</u> ร	w requires that the de been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in	n the u	nderlying cause give	n in Part I.			ute to the cause of death?		
ecoras	requii	eted			<u> </u>				Probably 4 Unknow	_	
r	ding Physician: The law h. After this certificate has funeral director, page 2 s	Completed						y pric ned? dea 2 No 1	ere autopsy findings available or to completion of cause of ath? Yes 2 KNo		
N I I a	rsicia s certi lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Nonpatient 2 ☐ ER/Ou	ıtnatic	ot 3 🗆 DOA Othe	26. Place of Death		e) ence 6 ☐ Other	(Emarity)		
0n 01	nding Phy th. : After this s funeral c	tion: To	27. Manner of Death 28a. Date of Injury 28b.	Time o Injury	f 28c. Injury Work			w injury occurred			
UNISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, str	eet, factory, office	1	28f. Location (St. City or Town	reet and Number n, State)	or Rural Route Number,		
	ne Hospit n 24 hours ne Funera bletely fille	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge of the basis of examination and manner stated.								
	To the vithing to the company of the	M	29b. Signature and title of certifier		29c. License		25	9d. Date signed (/	(Month, Day, Year)		
			P UV CX MS			60293	D	ECEMBER	8 2010	_	
			30. Name and address of person who completed cause of death (Item 23a) MURTUZA ALMED. M.D. 5401 OL	(Type,	Print)	D. D.	NAU CON.	am mo	21133		
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	2	barr Ro	no. pan	WHU 5 10W	- · · · · ·	-1103	_	
	Registr	ar	UEU I U ZUIU Reven A	9.	parker						

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Registrar

B. parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b, State of Maryland / Department of Health and Mental Hygiene) = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month V Q V Day 1040 P Sonya Princea Brown 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Levindale . Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🖵 F Davs Hours (Month, Day, Year) 7-19-1961 Director Marvland 1 Q 3029 items 23a or 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Baltimore N/AMd 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 U.S. A. 1418 N. Eden St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc þ 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mills Forman 12th Retail Mgt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Shirley Brown Thomas Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1418 N.Eden St., Baltimore, Md 21213 Princea Jones 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date cemetery, crematory or other classeph Brown F/H Crematory 1 🔲 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 12/02/10 Baltimore, MD 21. Signature of Funeral Service License 22Josephreno Fabrown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD PA 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence or, attending physician and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Month Day sate has been signed by the a page 2 should be detached to Part II. **Other significant condition**s contributi<u>ng</u> to death but *n*ot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? uchyarrythma 24a. Was an autopsy performe 24 hours after death.

Funeral Director: After this certificate 2 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Tyes 2 🗆 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one Itle of certifier 29b. Signature and 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar

X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December Physician/ 4:27 RM Richard Rogers Busch 7 , 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brightview of Whitemarsh Nottingham Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Nov 04, 1935 If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 75 Months Days Hours **Director** 215-34-0442 Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show or 28a-f shows notified at 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Baltimore Nottingham 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? ral", or items 23a o Examiner must be Funeral 8100 Rossville Blvd # 332 21236 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. Þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Retail event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Franklin Pierce Busch Irma Berlinicke traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Busch /Brother 7 Kilglass Ct. Apt. 301 Timonium, MD 21093 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Dec 08 1 Burial 2 remation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2010 Beltsville, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives any 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day 2 No 9 Unknown 9 Unknown ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed After this certificate 1 Yes 2 25. Was case referred to medi Be 26. Place of Death (Check only one) examiner? Hospital 2 Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (A 30. Name and address of person who completed cause of death (Item 23a) (T

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	uneral irector		5. Social Security Number 6. Sex 7. Ag 1 M 2 TF	73 Yrs. Iast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.					irth ay, Year,	irthplace (State or Foreign country)			
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Zan 12 shor	27 is n r traum		19a. Informant's Name/Relationship (Type, Print) Micheline Bowman - Daughte					ural Route Numb Bowie,		or Town, State, Z 20720	ip Code)		
Saltimore, permit. Page 1 and	If item or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of	f Dispositi			Date Date		Location - City o	r Town, State		
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								,	Approximate Interval Between				
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R	State egistra	e r	DEC 1 0 2010 Server 32. Register	's Signature	9								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Not-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ariel Medical Name (if not institution, give Examiner last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Saltimore Director or 28a-f show 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 ☐ No 10g. Citizen of What Country? Funeral items 23a mont Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, or. 1 Never Married 2 Married Black, White, etc Completed by 1 Yes No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 Divorced 4 Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ** DO NOT use retired) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ည 19a. Informan . Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Date cemetery, crematory or other injury or 4 Donation 5 Other (Specify) Signatur of Funeral Savice Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): that initiated events resulting in death) Last signed by the attending physician d be detached for use as the hurial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Pregnant at time of death 5 Other (specify) Month Yes 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown completed filled in by the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed' death? Yes 2 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending Natural work 1 Tyes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defitying Prijateland in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 81 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signatu

10-09410 John William Barr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

010 38868 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day December 7, 2010 Medical Examiner 1702 hrs John William Barr 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6 Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Months Days Hours Director 234-38-9161 1X M 2 F 82 07/25/1928 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Baltimore 28a-f show 1 Yes 2 X No Essex Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 E. Orville Road 21221 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Pages i and 2 should be filed within 72 hours after death wi rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married White, etc. 2 Married 1 X Yes 4 Divorced f Yes, Give Yeer 1950 **–** 1956 1 Yes 2 X No specify: White ρ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 8 Assembly Line Worker Automobile Mfq. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Charles Barr Crites 19a. Informant's Name/Relationship (Type, Print) ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leah Seay (Daughter) 1927 Sue Creek Drive, Essex Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 12/15/2010 Baltimore, Maryland Donation 5 Other Specify: 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee Old Eastern Avenue, Essex, Maryland 23a. Part I. see the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interva fai re. List only one cause on each line Between Onset and Medical Death a Multiple Injuries Immediate Cause (Final disease ≛xaminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and I be detached for use as the burial - tran Physician/Medical UNPENDED AMENDED the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. <u>6</u> 1 Yes 2 No 3 Probably 4 V Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has page 2 performed? death? this certificate Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 V ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day Year) Dec 7, 2010 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury Subject driver of vehicle involved in motor ___ Natural 5 Pending 1 Yes 2 ✔ No Director: I in by the I vehicle accident 2 Accident I in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) Stemmers Run Road @ Eastern Boulevard, Essex, Md determined (Specify) Local Street 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME O.C.M.E. December 8, 2010 Name and address of person who completed tause of death (item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Hea		l Hygien	ne	
			1 - State Registrar Certificate of De	ath	Reg. N	10.2010	38869
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The state of the s	Medic camin		Damica Brown 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	ration of Death		c. County of Death	
EX.	amm	er	Mercy Medical Center Baltimo			Baltimor	1 City
Fun	eral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Months Days H	Under 24 Hrs. 8. Date	of Birth oth, Day, Yeg	9. Birth	place (State or Boreign
Dire	ctor		Usual Residence of Decedent	1 12	1,2	010	ND
/land	12		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Mary a-f sh	iffied	ctor	MD Baltimore City Baltimore				1 Yes 2 □ No
iff the or 28	Se no	Dire	10e. Street and Number 10f. Zip Code		10g. C	Citizen of What Cou	ntry?
ath w	nust	by Funeral Director	3413 East Fayette Still 21724		US	A<	
fter de	iner	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	nic Origin? (Specify Yes lexican, Puerto Rican, e	or No- tc.)	14. Race - Ameri Black, White,	
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5-0 72 hc	dical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done durin	n a most of working	16b.	Kind of Business/Ir	dustry
121 within ene. than '	se Me	du	Elementary/Secondary (0-12) College (1-4or 5+) T N Fa N	4	1	INFa	v F
Maryland 21215-0036 d.2 should be filed within 72 hours aft th and Mental Hygiene.	ent, II	ပို		Mother's Name (First, M	Middle, Maide	en Surname)	
aryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show	tic ev	To Be	Dametris Samuel Kelly	iffany N	dical	a. Brau	SIO
lary 2 shou 1 and h is ma	anma		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and I	Number or Rural Route	Number, City	or Town, State, Zi	Code)
and and lealth	her tr		TI + PANY N. Brown - mother 3413 E. Faye		Ba/An	noll, M	D21224
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	or of		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	Date /		Location - City or To	
Itin artme ortant	injury 2.		4 □ Donation 5 □ Other (Specify) New Cathed (Cathed) 21. Signature of Funeral Service Ligensee 22. Name and Address of	12-17-20	10 B	altimor	e MD
Balt permit. Departr Imports	any ir		1+ome, PA, 2	Brad 1	ley-1	ASK TON	FUNERAL
STAIR			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.		itory arrest,	NS ROW	Approximate
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/Med Exami	-		resulting in death) Due to (or as a consequence of):				
		ē	Sequentially list conditions, if any, reading to immediate b. Due to (or as a consequence of).				
d le le	ansit	Examine	If any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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	se as	/Mec	IF FEMALE:		1		
death certific	for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Ves 2 № No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		1	23d. Date of deliv Month	ery Day Year
. 0 0	ached	nysi	1 ☐ Yes 2 No 9 ☐ Unknown 5 ☐ Other (specify)				
	se det	ру Р	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I. 23e.	Did tobacco	use contribute to t	he cause of death?
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g Phy	eral d	- 14	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Nursing Home 5 28d. Des	Residence cribe how inju		(y)
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DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	Delli .		29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time of		A - 41		
e Hos	ierely:	Medical	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	n, death occurred at the	time, date ar	s) and manner as and place, and due to	tated. the cause(s)
To th To th	comp	Me	29b. Signature and title of certifier 29c. License num	nber	29d. D	ate signed (Month,	Day, Year)
1			DANUEL, M.D. P180	723	13	01 20	Oio
Ø.)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
7	State		(avacia Andreson Tull 301 St. Pauls Piace, Ball 31. Date filed (Month, Day, Year) 32. Registrar's Signature	HIMUR M	0 210	199	
Reg	State gistra	~	DEC 10 2010 Server 32. Registrar's Signature 2010.				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Mereus Slessin 11 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number Baltimore Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**2**F Days Hours Min. Months NI Director MO Usual Residence of Decedent 10b. County 10c. City, Town or Location show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examinar must be ruffled at Director 1 □Yes 2 ☑ No timore rookl 10e. Street and Number of. Zip Code 10g. Citizen of What Country? by Funeral 21225 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 ☑No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Madic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ce 19a. Informant's Name/Relationship (Type. Prin) 19b. Mailing Address (Street and Number or Rur Route Number, City or Town, State, Zip Code) Jenny Mereus 3207 Quifpor Drooklyn, mo 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State athedra 12-17-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 1-ASKION FUYERAL HOMETH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Preterm disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending abundance and physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy NIA 23b. Was decedent pregnant NIA 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☑No 2 No 1 □Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 1 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 1 reprtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

301

31. Date filed (Month,

DEC 10

Baltimore

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul

23054

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For State		yland / Depa		th and Mental Hy		. 20071
	Physicia	an/	Registrar 1. Decedent's Name (First, Middle, La	R lack	Cer	ilicate of Deat	2. Date of De		3. Time of Death
	Medi Exami	cal	4a. Facility Name (if not institution, giv	1 (1)		4b. City, Town, or Locati	10	2 Day 4 Year 20 4c. County of Dea	
الر	Funeral			Spital Sex 7. Age (1)	n yrs. last birthday)		MOYE nder 24 Hrs. 8. Date of Bir	th 0 gi	rthplace (State or Foreign
	Director		214-38-8857 Usual Residence of Decedent	77	9 Yrs.	Months Days Hou			aryland
	aryland a-f shov fied at	Director	10a. State 10b. County MD Balt		Oc. City, Town or Loc	Halethorpe	ο		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th the Ma 3a or 28 t be noti		10e. Street and Number 200 1st Avenue			10f. Zip Code 2122		10g. Citizen of What C	ountry?
	death wi	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13. V		Crigin? (Specify Yes or No- cican, Puerto Rican, etc.)	United St	
9600	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates.		Yes 24 No Spec		Black, White Specify: Wh	
215-	in 72 ho e. nan "nat	omple	15. Decedent's (Specify only highest g Elementary/Seconday (0-12)		(Give k	ent's Usual Occupation rind of work done during n O NOT use retired)	most of working	16b. Kind of Business	Industry
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rylan	d Mental marked o	욘	Paul Ely Black,				Charlote Voy	ce	
, Ma	and 2 shoul Health and I tem 27 is m:		19a. Informant's Name/Relationship (Frances Black -				mber or Rural Route Numbe , Halethorpe,		p Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.		20a Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Speci	Removal from State		sition (Name of atory or other place) Crematory	Date Dec.8,2010	20c. Location - City or Glen Bur	
Balti	permit. I Departn Importa any inju		21. Signaturent Funeral Service licen		22.	Name and Address of Fa		Funeral Hom	ne, Inc.
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	plications that caused the	V' V/			7.6	Approximate Interval Between
of J	hysicia n, Medical	8 0	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or es a co	nsequence of:				Onset and Death
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9	ath certificate be executed attending physician and for use as the burial-transit	ical	. Sulting in death) Last	Due to (or as a co	nsequence of):				
Box 68760	ertificate iding phy se as th	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy				
. Box	Attending Physician: The law requires that the death certificate be executed at death certificate be executed extreming the state of the state of the state of the state of the state of the state of the state of the funeral director, page 2 should be detached for use as the burial-transity the state of t	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of del Month	livery Day Year
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F Vita	Physician: this certific ral director,	10 B	examiner? 1 Yes 2 No		2 ER/Outpatient	Other:	Death (Check only one) Nursing Home 5 Resid	ence 6 Other (Spec	ify)
o uo	anding fath.	Certificate:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		28b. Time of injury	28c. Injury at work? M 1 1 Yes 2	1	ow injury occurred	
Division of Vital	al or Atto s after de l Directo d in by tl	_ 4	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - building, etc. (Sp		t, factory, office	28f. Location (S City or Town	treet and Number or Run n, State)	al Route Number,
-	To the Prospital or Attending Private in the Prospital of the Funeral Director: After the completed filled in by the funeral	Medical	(Check 2 in Medical Exam)	ner: On the basis of exami	nation and/or investig	lation, in my opinion, death	nd place, and due to the cau occurred at the time, date ar	id place, and due to the c	auco(c) and mannor stated
1	vithin To the comp		29b. Signature and title of certifier	m n	or my knowledge, de	29c. License number	ate and place, and due to the	cause(s) and manner as	
1/	\	-	30. Name and address of person who o	completed cause of death	(Item 23a) (Type, Pri	nt)	001	12/4/	2010 Baltimore
X	Stat		DAVID Marke 31. Date filed (Month, Day, Year)	r MD / 32. Registrar's S		espetal 3001	South Ha	nover tree	Marylona
	Registra		DEC 1 0 2010	Desira A.	parker	<u> </u>			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Worth Vov /Medical Examiner 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Baltimore Gorsuch Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, **Funeral** Birthplace (State or Foreign Country) 1□ M 20 F Months Days Hours Min 6980 Director maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it with dight Evamina. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 rorsuch LSA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Assistant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle Maiden Surname, 10.1e ပ္ Williemae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gorsuch 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12-13-10 4 ☐ Donation / 5 ☐ Other (Specify) Dwings Mills, MD 21. Signature Juneral Service Lice inera Fredhilton Pass 23a. Party. Ent'r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, coleant failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Examir physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical signed by the attending of the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 → No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s peen si should ! 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No has 24a. Was an page 2 s autop performe 2 After this certificate 1 ∐Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 2 Other: 4 \sum Nursing Home Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ome 5 Desidence 6 ☐ Other 28d. Describe how injury occurred edidence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 1 ☐ Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

DHMH 17 Rev 1/2001

State

completed cause of death (Item 23a) (Type, Print

Signature

32. Registrar's

			Please Type or F			_	_	•
		•	For State Of State Of Registrar		artment of neath	h and Mental Hyg า	Reg. No. 2 0 1 0	38873
	Physicia Medic		1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Year	3. Time of Death
đ	Examir		4a. Facility Name (if not institution, give street and number of the st	,	4b. City, Town, or Location	on of Death	4c. County of Dear	th
~~~~	Funeral Director			Age (In yrs. last birthday) 66 Yrs.		der 24 Hrs. 8. Date of Birth Min. (Month, Day 6-13-	9. Bir 1934 M	thplace (State or Foreign untry) aryland
		L	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. Inside City Limits
	// Aarylan 8a-fsh tified	recto	MD Baltimore Co.	Notti				1 ☐ Yes 2 🖾 No
	th the Na or 2	Funeral Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
	eath wi	nne	58 Laurel Path Court  11. Marital Status 12. Was Decede	ent Ever in U.S. 13. \	21236 Was Decedent of Hispanic Conference of Yes, specify Cuban, Mexicon	Origin? (Specify Yes or No-	USA 14. Race - Ame	rican Indian,
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced  Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	ĭ No	f Yes, specify Cuban, Mexic 1 ☐ Yes 2 🖾 No Speci		Black, Whit	
21215-0036	nin 72 hou ne. i <b>han "nat</b> u <b>e Medica</b>	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 N /	(Give	dent's Usual Occupation kind of work done during m O NOT use retired)		16b. Kind of Business	
	led wit Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)	A   Fac	tory Worke	ther's Name (First, Middle, I	Warehou Maiden Sumame)	s e
ylan	ld be fi Mental arked atic ev	오	Fredrick Waters, Sr.		Н	ilda G. Rio	ce	-
, Maryland	id 2 shoul salth and n 27 is m er traum:		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  Chrissy L. Brooks-Dau			nber or Rural Route Number, Court Nott		
ore	ge 1 ar nt of He : If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from St		natory or other place)	Date	20c. Location - City or	
Baltimore,	permit. Pa Departmer Important any injury once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	22		cility Kaczorows		al Home, PA
	⊕ □ = e o		23a. Part 1. Enter the disease, or complications that cau			k Avenue Ba		MD ZIZZZ  Approximate
	Physician/ , Medical		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death)	Acute Per	al failur	e		Interval Between Onset and Death
	Examiner		Due to (or	as a consequence of):				weeks
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	as a consequence of):				
0	ath certificate be executed attending physician and for use as the burial-transit	ल्	resulting in death) Last  Due to (or	as a consequence of):				
3876	rtificate ling phy e as the	/Med	IF FEMALE: 23c. If yes, outco	mo of programay				
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	in the past 12 months?	th 2 ☐ Fetal death 3 ☐ nt at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
s, P.O.	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached	d by Pr	Part II. Other significant conditions contributing to dea	th but not resulting in the u	ınderlying cause given in Pa		bacco use contribute to	the cause of death?
ord	w requi	plete				24a. Was a	n 24b. Were au	topsy findings available completion of cause of
Rec	The la	Com				autop: perfor 1  Yes	med? death?	s 2 No
/ital	sician: s certific	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:	patient 2 🗆 ER/Outpatier	0.00	Death (Check only one)  Nursing Home 5  Resident	enne 6 🗆 Othor (Spec	36.)
n of V	ding Phy h. After this funeral d	ate: To	27. Manner of Death  1 Natural 5 Pending  28a. Date of (Month,			28d. Describe ho	ow injury occurred	nry)
Division of Vital Records,	or Attendated after deat Sirector: in by the	Medical Certificate:		Injury - At home, farm, str , etc. <i>(Specify)</i>			reet and Number or Ru n, State)	ral Route Number,
۵	Hospital 4 hours 7 hours 7 hours 14 hours 15 hours 16 filled	dical	29a. Certifier 1 Certifying Physician: To the bes Check 2 Medical Examiner: On the basis	of examination and/or invest	tigation, in my opinion, death	n occurred at the time, date ar	nd place, and due to the	cause(s) and manner stated.
	To the within 2 To the comple	×	only one) 3 Certifying Nurse Practioner: To 29b. Signature and title of certifier	the best of my knowledge, o	death occurred at the time, d 29c. License numbe		cause(s) and manner as 29d. Date signed (Monti	
			> Estorall	<u>.</u>	0005	4801	Decem	Ser 3,2010
			30. Name and address of person who completed cause	of death (Item 23a) (Type, F		sc, ms 2	1224	
	Sta Registr			istrar's Signature			<u></u>	
	negistr	41	HILL TO COLO	14. 19.00				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 08 MAJER IBIUAC Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMER 055 HOSPITA: VE R PR SUL 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Month, Day, J 1 M 2 D F Months Davs Hours Min Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 196 ¥ DR 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Forces? þ 1 Never Married 2 Married 1 ☑Yes 2 ☐ No Specify: MEXICAN If Yes, Give Year or Dates Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4, or 5+) INFAN NEANY A Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avona 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည ELIZABETH CASTRO GONZALEZ R10 MAJE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CROSS ATIP. 200 FOREST COLEN HOS 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 □ Donation 5 N Other (Specify) in state 21. Signature of Funeral Service Brate Affato Board 655 W. Baltimore Street 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a. Part shock Approximate Interval Between Onset and Death Physician/ BAIVHOU 8 GESTATIONA! disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner RE BIRT TER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) physician Physician/Medical certificate be the attending IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown use 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ģ Month Day 5 Other (specify) detached the signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No has page 2 this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? iniury 1 Natural 5 Pending Accident 2 🗆 No Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar RACHE

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

1200

Registrar's Signato

FOREST

COLEN

SPRING MD 2090

SUUER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month -254 2 Ulysses George Harry Crouse Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Jf Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Davs Hours (Month, Day, Year, **Director** 73 1937 218-34-0833 Maryland 28a-f shov 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Carroll New Windsor 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 2791 Miles Court 21776 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, ed Forces? Yes 2 No Black, White, etc. Armed Fo "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates.1953-75 1 Yes 2 X No Specify. Specify: 3 ☐ Widowed 4 🔀 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) lab technician flooring mfg. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Crouse Helen Lambert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Sylvia R. Neiderer/daughter 63 Test Rd. Hanover, PA 17331 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 🗆 Burial 2 🔀 Cremation 3 🗖 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 12/9/2010 Sykesville, MD 21. Signature of Funda Service Licenses 22. Name and Address of Facility Hartzler Funeral Home Jarine 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line ediate Cause (Final Immediate Cause (Final DNCESTIVE HEART Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine cause. Enter Underlying Due to Connell no insertioner of Wb Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 🗙 No 3 ☐ Probably 4 ☐ Unknown RUBRA THEMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Tyes 2 No 욘 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Accident 5 Pending work? 1 Pes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30263 12-03-10

State Registrar 200

31. Date filed (Month, Dav. Year)

DHMH 17 Rev 7/2009

AVENUE

32. Registrar's Signature

WESTMINSTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEMORIA

		Please	State of Marylan				•		<b>.</b>		
	•	For State	State of Ivialylan	•	tificate of i			2011	38876		
		Registrar  1. Decedent's Name (First, Middle, Last	")		·		2. Date of Dea	Reg. No.	3. Time of Death		
Physicia Medi		Lynn Ar	thur Cross				Dec'emb	er ^{Day} 2017			
Exami		4a. Facility Name (if not institution, give s Frederick Me)	street and number) morial Hospita	ıl	4b. City, Town, o	r Location of Death Frederic			4c. County of Death Frederick		
Funeral		Social Security Number 6. Se	x 7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th 9. E	irthplace (State or Foreign		
Director		136-46-8595 Usual Residence of Decedent	<b>X</b> M 2 □ F 58	8 Yrs.	Mortins Days	Hours Min.	July 2	7, Year) 1952 1	New Jersey		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show myn hinny or other traumatic event, the Medical Examiner must be notified at once.	tot	10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits		
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th the	la l	10e. Street and Number			10f. Zip Code	24702		10g. Citizen of What (	-		
ath w	Funeral Director	7 Monocacy Co	12. Was Decedent Ever in U.S	3. 113. \	Vas Decedent of H	21793 Hispanic Origin? (Sp	ecify Yes or No-		S.A. nerican Indian,		
6 er de or ite		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 🕱 No	1	f Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, Wh			
DO3	ed	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		Yes 2 🔀 No	Specify:		Specify:	White		
"nate	Completed by	15. Decedent's Ed (Specify only highest grad		(Give i	dent's Usual Occup kind of work done	during most of work	ring	16b. Kind of Busines	s Industry		
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Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exem		19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Street			r, City or Town, State, 2	Zip Code)		
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altimore, rmit. Page 1 and partment of Hea portant: If item y Injury or other		20a. Method of Disposition  1 XBurial 2 Cremation 3	Removal from State	emetery, cren	sition (Name of natory or other pla		Date	20c. Location - City			
ti. Pag rtmen rtant:		4 Donation 5 Other (Specify	Lin		Cemeter		2/2010	Unionville	<del>'</del>		
Bal permi Depar Impo any Ir		21. Signature of Funeral Service Ligense	Xanther .					Funeral Hom cytown, MD			
		23a. Part 1. Enter the disease, or comp	lications that sed the death		1802 Liber the mode of dyir				Approximate		
Physician/		shock, or heart failure. List only or Immediate Cause (Final	0 1 11	2 104	yocard	3-1 3-	farct	1.00	Interval Between Onset and Death		
Medical		disease or condition resulting in death)	a. Propable  Due to (or as a consequ		Jocara	1001 140	(arc)	1011			
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be executed sician and burial-transi	xar	Cause (Disease or iinjury that initiated events resulting in death) Last	c Due to (or as a consequ	ience of:							
ox 68760 eath certificate be executed attending physician and for use as the burial-transit	g	resulting in deathly East									
68760 certificate b nding physi			a								
certif	an/N	23b. Was decedent pregnant	23c. If yes, outcome of pregnal		Ectopic pregnan	CV		23d. Date of c	lelivery		
Box death c	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of d		Other (specify)			Month	Day Year		
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ords, P.O. Be requires that the de been signed by the should be detached	Completed by Physician/Medi	Tarkii. Outer significant conditions co	minbaling to double but not room	aiting in the a	ndenying dade gi	TOTAL CALL		Yes 2 No 3	i .		
rds requir	etec						24a. Was		utopsy findings available		
Records, The law requires sate has been sig	dw						autop	prior to rmed? prior to death?	completion of cause of		
un: Th ifficate or, pa	Be Co	25. Was case referred to medical			26. P	lace of Death (Chec	1 Yes	2 No 1 U Y	es 2 🗆 No		
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of ng Ph fter th		27. Manner of Death 1 ▶ Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. injur worl	y at		ow injury occurred			
ion tendificath. tor: At	ifica	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 ☐ No	-				
Division of Vital all or Attending Physician: staffer death.	Certificate:	4  Homicide determined	28e. Place of Injury - At ho building, etc. (Specify,		eet, factory, office		28f. Location (S City or Tow	Street and Number or Fi vn, State)	ural Route Number,		
Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate lawithin 24 hours after death.  To the Funeral Director: Affer this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Phys	ician: To the best of my knowle	edge, death o	occured at the time	e, date and place, a	nd due to the car	use(s) and manner as s	tated.		
n 24   he Fu	Med		ner: On the basis of examination e Practioner: To the best of my								
with To t	3451	29b. Signature and title of certifier			29c. Licens			29d. Date signed (Mon	th, Day, Year)		
		a Me	MD			35267		12-08-20	10		
12		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, P	rint)	STE	2 ad anic	kmi	21701		
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture .	UTI TO	1 21, 11	) TOW IIC	12 1111	01101		
Registr		DEC 1 0 2010 /2	32. Registrar's Signat	wes							

Christine Reiter (		ngton Stat 1-For State	e of Maryland	/ Depa		of Hea	lth an			е	20	0	3887
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any		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation							10d. Inside City Limits
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ath wi	Funeral	11. Marital Status 1 Never Married 2 Marri	12. Was Deceden  Armed Forces	?					n? ( Specify Ye: Puerto Rican, e		14. Race - White,		an Indian, Black,
ifter de		3 Widowed 4 Divorce	1 Yes 2 ed If Yes, Give Yeer	X No	1	Yes	2X No	specify:			Specify:	Whi	te
hours a	ed b	15. Decedent's Education (Specify	, , ,					tion (Give ki	nd of work done se retired)		6b. Kind of Bus		_
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	Elementary/Secondary (0-12)	College (1-4 or 4	5+)	Owner				ŕ		Emmerson Stand	n Sı	nowball
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nor ages lent of h		1 Burial 2 X Cremation 4 Donation 5 Other Speci		iaie	rematory or view			,	12-09-2	010	Baltim-	ore	, MD
altir mit. F partme porta	t	21. Signature of Funeral Service Lic	ensee	1 7									of BelAi
	4	Buch a U	Jeller	d the death	I	nc 61	.W .	MacP	hail Rd	Be1	Air, MD	210	) 1 4 Approximate Interval
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	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	c.	sequence or	).								
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	전	Part II. Other significant condition	<ul> <li>contributing to deal</li> </ul>	th but not re	sulting in the	underlyin	ig cause	given in Part	I. 23e		cco use contrib	_	ne cause of death?
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Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page		29a. Certifier 1 CertifyIng Phys	iclan: To the best of m	ny knowledg	e, death occ								
To the within To the comple	Medical		ner: On the basis of exa and manner stated	mination an	d/or investig				rred at the time				
	≥	29b. Signature and title of certifier				29	ec. Licens O.C.	se number M F			9d. Date signed December 6	·	
	-	30. Name and address of person wh	o completed cause of	death (Item	23a)		J.U.			'		, 201	•
)			ant Medical Exar	niner 1	111 Penn	Street,	Baltim	ore, MD 2	1201				
Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	ha de	,							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Blanche Eldora Cruz-Bey 6:57 A M December 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year) 20,1942 If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🗓 F Hours Country) New York 68 Director 115-34-7929 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f showons any injury or other traumatic event, the Medical Exercises. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's 1 Yes 2 K No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20707 7114 Piney Woods Place United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 X Married Yes 2XXNo 1 Yes 2 No Specify: Black If Yes, Give Specify 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's Elementary/Seconday (0-12) College (1-4 or 5+) County Government Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ဂ္ဂ Hughey, Sr. Sheffield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Cruz-Bey / Husband 7114 Piney Woods Place, Laurel, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Chesapeake Crematory 1 Burial 2 Caremation 3 Removal from State 12/10/2010 Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Rapp Funeral and Cremation Services M00382 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pulmonary Emboli Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) g ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): - 12 - 04 -Box 68760 A Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) the attending IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \( \sum \) Yes 2 \( \mathbb{X} \) No Month Year Dav Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Attending Physician: The law requires that 23e. Did tobacco use contribute to the cause of death? Completed by lanc Retroperitoneal Bleed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 \sum No 1 ☐ Yes 2 🛛 No of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 😾 No Be 1XXInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred F42 - Division 1 X Natural 5 Pending work 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) December 4, 2010 D67986 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Yuneng Li M.D., 8600 Old Georgetown Rd., Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32. Registrar's Signature 10 Registrar DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9, S. Margaret Carew December 2010 7:13 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖼 F 218-09-5541 Director 93 June 16,1917 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified Director 1 ☐ Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? ral", or Items 23a or Evancioer must be r permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must once. Funeral 711 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Technologist Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronald A. O'Hanley Sara K. McCall ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1830 Congressional Village Dr. #3104; Middletown, DE William R. Carew, Jr. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 12/13/10 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Serice Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue: Catonsville Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Failure to thrive /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1 ☐Yes 2 ☐No 1 ☐ Yes 2,12/No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1. Natural 5 ☐ Pending investigation ours after death.

Neral Director: A

filled in by the fu death. 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December 07, 2010 Catherine Anne Cover 7:30 P. M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Baltimore County Broadmead Retirement Community Cockeysville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day) Months Days Hours Min. 1 ☐ M 2 ☐ KF Aug. 24, 1929 81 Baltimore, MD. 213-32-5278 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Baltimore County Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 13801 York Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 X Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Milton J. Dance Center Elementary/Secondary (0-12) College (1-4or 5+) 12 Social Worker 04 at GBMC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilson Turner Ballard, Sr. Susan Catherine Reaney 19a. Informant's Name/Relationship (Type. Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms.Catherine C. Willson 2134 VT Rte.17 Starksboro, Vermont 05487 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State (Harford County) Evans Fure al Creek and Wednesday 4 Donation 5 Dother (Specify) Dec. 08, 2010 Cremetion Services, Inc. Forest Hill, Maryland Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Page and Address of Facility Funeral & Cremation Center, P.A. First Lic. #M00677

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Parel Lic. # Timonium, Maryland 21093-2215 Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 1 ∐Yes 2 DNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 D Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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be notified Director

Funeral

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Completed

event, the Medical Examiner must

/Medical

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State Registrar

within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Exitiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6, Virginia Mary Clayton December 2010 2:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Meadows Retirement Community Baltimore Glen Arm Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🖾 F Director 1915 218-01-0787 Maryland Mar. 21, Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Madical Examiner is ust be notified at Director 1 TYes 2 □ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 Idlewild Road 21014 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 Maryland 21215-0036 1 ☐Yes 2 🛛 No Specify: þ Specify: 3 Nidowed 4 Divorced Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 7 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental Η permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce. John Royal Schmidt ဥ Susan Meta Poehler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary V. Cardwell / Daughter 513 Idlewild Road, Bel Air, MD 21014 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Pk 12-11-10 Baltimore, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21014 21. Signature of Funeral Service Licenses + Athleen Dantwasce 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ysician Ceresionascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of). it any, leading to immedia cause. Enter Underlying Cause Or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by tral 1 ☐ Yes 2 🖢 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy page certificate perform Division of Vital 2 🗆 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Man or of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No after death Director: , d in by the f 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

Date filed (Month, Day, Year,

30. Name and address of person who completed

2010

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DHMH 17 Rev 1/2001

e of death (Item 23a) (Type, Print)

6701

Registrar's Signature

29c. License number

N Charles Mreet

Dec 07, 2010 Baltinune Ma 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 December 11:00A M Stanley Costrell Edwin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Gaithersburg 217 Booth Street, Apt 429 8. Date of Birth (Month, Day, Year Sep 30, 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 **X** M 2 □ F Months Days Hours 004-14-8256 Director Maine 97 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Director 1 Yes 2 No Gaithersburg Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20878 217 Booth Street, Apt 429 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Ves 2 No
If Ves, Give
Year or Dates. 1943–46 If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Completed 3 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working State Department filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Washington, DC Chief Historian 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I ၉ Cohen Annie Costrell Solomon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 12512 Carrington Hill Drive Gaithersburg, MD 20878 Linda Hermesman/daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Page 1 Department of Important: If it any injury or o once. cemetery, crematory or other place) ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Journey Crematory 12/11/2010 4 Donation 5 Other (Specify) Woodbine, Maryland Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Thomas M00957Beverly L. Heckrotte, P.A. Clarksville, MD 21029 uanita 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Years** Immediate Cause (Final Physician/ years Bladder Cancer disease or condition resulting in death) Medical Due to (or as a consequence of [']Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day ò Month Year Pregnant at time of death ned by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Tes 2 🗌 No Yes 2X No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, the Funeral Directory filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

JOX

DHMH 17 Rev 7/2009

State

Registrar

D0061083

9707 Medical Center Drive, Suite 300 Rockville, MD 20850

December 8, 2010

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Thambi

Pául M.

31. Date filed (Month, Day, Year)

1 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38883 Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Year FNO 12:37 PM DECEMBER -ARUTH 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death RANDALLSTOWN NORTHWEST BALTIMORE HOSPITAL . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **№**M 2 🗆 F Months Hours (Month, Day, **Director** Trindad June unk Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 Xes 2 ☐ No 28a-f b 10e Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral **23**a USA items 2 filed within 72 hours after death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3altimore, Maryland 21215-0036 Africas If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced injury or other traumatic event, the Me Ical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Fork Be Department of Health and Mental H Important: If item 27 is marked — any injury or Att 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide ဂ NLW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) verald wentworth 421 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 12-15-2010 Donation 5 Other (Specify) re of Funeral Service Licens 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PERFORATION BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last burial-transit COLON CANCER and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? the funeral director, page 2 should be detached for Month Day Year the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 FAILURE REMAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 death? 2 X No ☐ Yes 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No Other: ဂ 1 MInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🜠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 AUMED, MURTUZA M.D. OLD GOURT 31. Date filed (Month, Day, Year)

2 Medical Examine
3 Certifying Nurse

of certifier

0 2010

(Check only one)

29b. Signature and til

DEC

82. Registrar's Signature

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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2010

actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Funeral Director		5. Social Security Number 6. S	lex 7. Age IM 2 □ F	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bi		9	Birthp	place (State or Foreign try) Land
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permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		Mrs. Betty M. Con:	rades / Wi			Chancefo	ord R						and 21228
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1 Certifying Physical Exami	sician: To the best of e	my knowledg	ge, death o	ccured at the time	, date and	place, an	d due to the ca	ause(s) a	ind manner a	s stated	d. se(s) and manner stated
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Stat Registra		31. Date filed (Month, Day, Year)	completed cause of de D 32. Registra	r's Signature									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 7,2010 Physician/ 9:50 GLADYS L CALLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Greater Baltimore Medical Center 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Unde 5. Social Security Number 6 Sex **Funeral** Hours 1 M 2 F 0571271915 95 Director 171-14-6400 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County with the Maryland Director 1 🗌 Yes 2 😿 No BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral USA 21208 725 MT. WILSON LANE, #527 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married ☐ Yes 2X No Yes, Give 1 Yes 2 No WHITE 3 ▼ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve once. ည SHUGERMAN LONG ANN HAIMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 127 WEST LEE STREET, BALTIMORE, MD SALLY NEUSTADT/DAUGHTER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) 12/08/2010 COLUMBUS, OH GREENLAWN CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Approximate Interval Between Onset and Death 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final 2 DSIS 1 WC Physician disease or condition resulting in death) Medical Due to ( as consequence of): renal Failure rte Examiner WK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No fo Month Dav Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1  $\square$  Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director, After this certificate I completed filled in by the funeral director, page 26. Place of Death (Check_only one) 25. Was case referred to medical Be | examiner? Hospital 2 🗹 No 1 🗌 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes 2 🗎 No 1 Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ 3 [ only one) 29b. Signature and title of certifier 105-2197 R. Motagi, 10. Name and address of person who completed cause of death (Item 23a) (Type, Print)
REKA MOTAGI, GB MC 670/N. CA 6701 N. Charles street, Baltimore MD 21204 30. Name and addres

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 0.3^{Day} 2010 Michael Henry Duschl Jr. 3:50p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Ritchie N/A Baltimore If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 - F Months 02707717952 Director 58 Maryland 218-58-8512 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Ex-miner must be notified at 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 No N/A MDBaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7920 Eastdale Rd. 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1XX Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Be Completed by 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Laborer Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r and Mental F ပ Michael H. Duschl Sr. Elizabeth unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Joann Evans(sister) 286 Montrose ave., Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State Joseph Hard Crematory ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/05/10 Baltimore, MD 21. Signature of Funer I Service Licensee PASTER HAND PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing indeet). Physician/Medical Examiner Due to for as a consequence of been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li relaide.

Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Vital Records, Hospital or Attending Physician: The law requires 1 ⊈Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hyper calcemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 🔼 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral director. 4 Nursing Home 5 Residence 6 C Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 Natural injury Accident Investigation 3 Suicide
4 Homicide 6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Deficing rights and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) I Makare 12/3/10 Langes, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Day, Year) egistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Yelba Esmeralda Deckert 2010 Dec. 6 12:53A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring 733 Easley St Social Security Number Age (In yrs. last birthday, 9. Birthplace (State or Foreign Funeral 8. Date of Birth 10940.50411923 Country N<u>i</u>caragua 1 M 2 X F 87 Months Hours 579-40-5111 **Director** Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits notified at Director Silver Spring 1 Yes 2 No Montgomery 10f. Zip Code 10e Street and Number ō 10g. Citizen of What Country? must be Funeral 23a USA 20910 733 Easley St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian Examiner Armed Forces? Black White etc 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 ✓ Yes 2 □ No Specify: Nicaraguan White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Shows ... n and Mental Hygiene.
27 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beauty Manacurist Be 17. Father's Name (First, Middle, Last) ^{18.} Mother's Name *(First, Middle, Maiden Surname)* Esmeralda Pineda ည Erasmo Ochoa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 8505 Hempstead Ave. Bethesda, MD 20817 Denise Roarty/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. Dec. 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. Beltsville, MD 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilNapp Funeral & CremationService 21. Signature of Funeral Service Licensee MO1585 933 Gist Ave. Silver Spring, MD 20910 Kelbecc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final 4On Death Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for Month Year Day Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be d 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No has page 2 this certificate 1 Yes 2 No ector. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 🕱 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗡 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, Year) 1 Matural 5 Pending 24 hours after death.

Funeral Director: A 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Dec. 6, 2010 D19400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 344 University Blvd. W., #211, Silver Spring, MD Africano, MD Ernest State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38888 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ DeVaughn Mildred L. 2010 9:37 A December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 316 Spry Island Road Joppa If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🛣 F September 12,1925 212-20-3391 Maryland Yrs 85 **Director** Usual Residence of Decedent 28a-f show 10b. Count 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 Yes 2 XNo Edgemere Maryland Baltimore ō 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral 21219 USA 2125 Maple Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 XNo þ 1 Lu Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify. 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry filed within 72 hall Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 12 years Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) should be file h and Mental H ပ Marie Mardega Donald Schenk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh.
Department of Health an
Important: If item 27 is r.
any injury or Daughter Donna Hemling 4055 Beckleysville Road, Hampstead, MD. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December Burial 2 Cremation 3 Removal from State Dundalk,Maryland Sacred Heart of Jesus Cem. 11, 2010 4 Donation 5 Other (Specify) f Funeral Service Lice Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. Signat Firet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. Interval Between Onset and Death shook Immself le Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Examiner 5 years Aortic stenosis Sequentially list conditions, if any, he sing Limit diate cause. Enter Underlying Cause (Disease or iinjury Examine Due to lor as a consequence of: signed by the attending physician and be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obesity 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Records, Completed been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has s certificate has the director, page 2 s autopsy performed? Yes 2X No death? 2 🗌 No 1 Tyes 25. Was case referred to medica Division of Vital or Attending Physician: 26. Place of Death (Check only one) Be Son's examiner? Hospital: 1 Tes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work?
1 Yes 2 No s after death. Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State within 24 hours at To the Funeral D completed filled in Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature ar

Thomas

title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ucan

5505

32. Registrar's Signature

Hopkins

29d. Date signed (Month; Day, Year)

Bayview Circle, Balto. Hd 21224

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) DECEMBER 04 2010 GEORGE ANDREW DORN Physician/ M 2:42 A Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner HARFORD FOREST HILL HEALTH & REHABILITATION FOREST HILL | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | 9. Birthplace (State of Months | Days | Hours | Min. | 4 Hours | Min. | FEB. 12 , 1929 | Maryland 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Funeral 1**X** M 2 □ F Director 81 216-24-0058 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director be notified 1 ☐ Yes 2 X No Bel Air Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 21015 USA items 23a Funeral 2130 Northridge Drive the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 0 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: Specify: If Yes, Give White "natural", 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Shipping Long Shoreman 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ဥ Lillian Catherine Bowers John Randolph Dorn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Air, Maryland 21015 Paul J. Barale / Step Son Northridge Drive, Bel Saltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 XBurial 2 Cremation 3 Removal from State 12-8-10 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition eliun cu Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Year been signed by the atte should be detached for Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an OPO prior to completion of cause of death? autopsy performed cate has page 2 s 1 ☐ Yes 2 ☐ No 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🔲 No 24 hours after death. Funeral Director: A Accident Investigation within 24 hours after death To the Funeral Director: / completed filled in by the f 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Decombec 032290 105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

DR. DAVID DUNN- 615 W. MACPHAIL ROAD- BEL AIR, MD 21014

32. Registrar's Signature

Darke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ December 9°, 201°0° ETIENNE 7:15P Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore Social Security Number 9. Birthplace (State or Foreign Hall! 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Sex 1 M 2 XX Months Days Hours Director 23 0*9*%6674987 Usual Residence of Decedent of Health and Mental Hygiene. item 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he motified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A Cap-Haitien 1 Yes 2XX No Haiti 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 414 Rues 14-15-N None Haiti Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 XX Never Married 2 Married É Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🕅 📉 o If Yes, Give Year or Dates Specify 3 Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrick Etienne Franciette Lauvince 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Rues 14-15-N Cap-Haitien Haiti Franciette Lauvince Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Kremation 3 Removal from State GreenMount Crematory 12/11/2010 Baltimore, Maryland nature of Funeral ce Lic 22. Name and Address of Familytchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or companies shock, or heart failure. List only or fications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) od Medical ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has no hard the content of the Funeral Director. been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Year 9 Unkno Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 DAN 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 seempleted filled in by the funeral director, page 2 seempleted filled in by the funeral director, page 2 seempleted filled in by the funeral director, page 2 seempleted filled in by the funeral director, page 2 seempleted filled in by the funeral director and filled autopsy perform 2 1 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier O 5 address of person who completed cause of death (Item 23a) (Type Print)

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland				and Mental H	ygien	e	1 (	00001
		_	Registrar  1. Decedent's Name (First, Middle, Last)			Cer	tificate of I	Death	1.5	Reg. N	lo.	1U	38891
	Physicia	n/		E	_1_1	Con			2. Date of D		27 :	2010	3. Time of Death
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1	Examin	er	2553A Buckeystown	,			4b. City, Town, o	mstow		4	c. County		erick
	Funeral		5. Social Security Number 6. Sex		e (In yrs. las	st birthday)	If Under 1 Year		24 Hrs. 8 Date of B	irth		9. Birthp	lace (State or Foreign
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7	how	ក	10a. State 10b. County		10c. City,	Town or Lo	cation					10	Od. Inside City Limits
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	or 28	اق	10e. Street and Number	LON			10f. Zip Code	COWII		10g. (	Citizen of \	What Count	try?
nd 21215-0036	the Within 7.2 rouls are bean with the waysand tal Hygiene.  3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	2553A Buckeystown	Pike				21710	)		Ţ	U.S.A	•
į	item:	Fun	11. Marital Status	Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of H	Hispanic Or	igin? (Specify Yes or No n, Puerto Rican, etc.)	)-		e - America	
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lan j	d Mental marked matic ev	욘	Albert Gillis Eswo	rthy				Er	cie Neomia	Ald	rida	ė	
ary	I and z should be lik if Health and Mental I item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (Type,			19b. Mailir	g Address (Street		er or Rural Route Numl				ode)
Σ	1 = N = 1		David G. Esworthy/	son		5807	Leslie	Lane	Mt. A	iry,	MD :	21771	
e,	of Heal fitem		20a. Method of Disposition			ace of Dispo	sition (Name of natory or other pla	ice)	Date			- City or To	wn, State
ב <u>ַ</u>	rage I ment of ant: If it ury or o		1 🔀 Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State		-	rove Cem		12/1/2010	nr	. Mt.	Airy	, MD
Baltimore, Maryland 21215-0036	Definit. Page Department of Important: If i any injury or once.		21. Sign sur of Funeral Service Licenses	V/ h	11				ity Hartzler				
n	20 = 20	(1)	atharine V.	Vaille	er		1802 Lib	erty	Rd. Libe	rtyt	own,	MD 2	1762
P	nysician/	EL 3	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one c Immediate Cause (Final disease or condition	tions that caused ause on each line	€.		er the mode of dyi	ng, such as	s cardiac or respiratory a	arrest,			Approximate Interval Between Onset and Death
1	Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):							
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09/	phys the	edic	d. ,										
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Box	atter	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant a			Dectopic pregnan Other (specify) _	су					Day Year
). E	by the arched	hys	9 🗌 Unknown	g Unknown									
O.	ned be det	by P	Part II. Other significant conditions contri	buting to death b	ut not resu	Iting in the u	nderlying cause g	iven in Part	1. 23e. Did	tobacco	use cont	ribute to the	e cause of death?
ds,	en sig	ed							1 [	Yes	2 🗌 No	3 Prob	ably 4 Unknown
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ž ž	ate ha	ا س							per 1 □ Yes	formed?	No	death?	•
<u> </u>	r this certificate ha	Be (	25. Was case referred to medical examiner?						ath (Check only one)				
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to a	h. After t funera	ate:	27. Manner of Death 1	28a. Date of inju (Month, Day	ry v, Year)	28b. Time of injury	28c. Injui wor	k?	28d. Describe	how inju	ury occurr	ed	
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Division of Vital Records,	after death	Certificate:	4  Homicide determined	building, etc		ne, farm, str	eet, factory, office		28f. Location City or To			er or Rural i	Route Number,
ם ז	The Funeral Director, After this certificate has been signed by the atternor completed filled in by the funeral director, page 2 should be detached for	edical	29a. Certifier 1 Certifying Physicia	n: To the best of	my knowle	edge, death	occured at the time	e, date and	place, and due to the	callede)	and mann	er as states	1
H	e Fun	ledi	(Check 2 Medical Examiner:	On the basis of e	xamination	and/or invest	tigation, in my opini	ion, death o	occurred at the time, date	and place	ce, and du	e to the cau	se(s) and manner state
<u> </u>	within 2 To the comple	Σ	29b. Signator and title of certifier		230c Of HIS		29c. Licens		and due to	1		d (Month, D	
			Dr.				000	622	23	1	2/6	/10	
	8		30. Name and address of person who comp	oleted cause of d	eath (Item	23a) (Type, F	rint)					<del>'</del>	
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State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No, ent's Name (First, Middle, Last) 2. Date of Death **Physician** Year ames EVINS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner (In vrs. last birthday) Yrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 226-40-699 Months Days Hours 1 M 2□ F Director Usual Residence of Decedent th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantinar must be mailibed at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits timore 1 Mes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces?

No Yes 2 □ No IFYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done durin Tre. DO NOT use retired) condary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 1 and 2 should be 1 Health and Mental ၉ 19a. Informant's Name/Relationship (Type Health a rginia Zvi Item 27 Baltimore, od of Disposition Pages 1 permit. Pages Department of Important: If It any Injury or o **X**Burial 2 ☐ Cremation 3 Removal from State 4☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cayenitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): the burial-trans The law requires that the death certificate be execu resulting in death) Last Due to (or as a consequence of): the attending physician use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. I cate has been signed by the page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Yo 24a. Was an certificate has autopsy performed? Yes 2 MNo 1 ☐ Yes Physician: After this certification, I 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending atural 5 Pending investigation 21 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one)

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DHMH 17 Rev 1/2001

State

29b. Signatur

0

Registrar

ise of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2 2130 pm Day Physician/ Enac . Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner mutimore. (enter 8. Date of Birth (Month, Day, Ye March 23 9. Birthplace (State or Foreign If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) Funeral Days Virginia Hours Min 1 □ M 2**X** F 213-36-4158 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County Director Middle River 1 Yes 2X No Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2115 Cockspur Road USA 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Yes 2 No þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Housewife 9 years Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Lucy Wright Robert Foster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 2115 Cockspur Road, Middle River, Maryland 21220 Daughter Barbara Leith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 1 Burial 2 Tremation 3 Removal from State Baltimore, Maryland Bayview Crematory 10, 2010 4 Donation 5 Other (Specify) Signature of Funeral Service Ocenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD M01176 fer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to (or as a consequence-of) ongestu the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Pregnant at time of death signed by the aid be detached for 1 Yes 2 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No s certificate ha lirector, page 2 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical director, Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 8710 Emge Rd Center romwell 31. Date filed (Month, Day, Year) State 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38894 State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year December Erauth 1214 PM 07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bayview Johns Medical Cente Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-11-1938 Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2**X** F Months Hours 71 Director MD 213-34-0535 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Baltimore Dundalk MD 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21222 2790 Mooregate Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11, Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes . If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**o Specify 3 Widowed 4 Divorced Completed White Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk Administration Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Edward Thompson Maxine Humes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2790 Mooregate Rd., Dundalk, MD 21222 Phil Erauth - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Atlantic Crematory 12-10-10 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bradlew Ashton Funeral Home DA 2134 Willow Spring Road, 21222 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Ahoni disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ardiac Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Pregnant at time of death 5 Other (specify) 4 | Pregnam cate has been signed by the a page 2 should be detached to 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe After this certificate has 1 ☐ Yes 2 ☐ No Yes 2 K No within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔯 No Certificate: To 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 2 Accident
3 Suice 1 Natural 5 Pending 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Certifying Prijection. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES-000 December 07, 2010

State Registrar MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eastern

Baltimore, MD

Ave.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ М William Lloyd Ensign December 2010 2140 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Casey House 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Hours Min (Month, Day, Year) 1 🖾 M 2 🗆 F Trinidad Director 523-38-5795 81 Dec Usual Residence of Decedent f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 XYes 2 No Marvland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8300 Burdette Road, D621 20817 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates. 1953–56 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Architect Architecture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lloyd Gordon Ensign Barbara Hobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra June G. Ensign /wife 8300 Burdette Road, D621 Bethesda, Maryland 20817 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Final Journey Crematory 12/11/2010 4 Donation 5 Other (Specify) Woodbine, Maryland 21. Sign or re of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Homas M00957 Beverly L. Heckrotte, P.A. anta 23a. Part ∜ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Intracranial Hemmorhage (multiple) 3 vears disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. ed by the attending physician and detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown s been signed by should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\searrow$  Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 s 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? Other: 1 Yes 2 3**8**No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Director: After **X**Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 37142 December 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coleman, M.D. 1355 Piccard Drive Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month December Day 8:14 2016 Daniel Lee Flohr Physician/ Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick **Examiner** Frederick Frederick Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number (Month, Day Year) 1953 **Funeral** Maryland 1 🛛 M 2 🗆 F Director 218-64-3153 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County should be filed within 72 hours after death with the Maryland eand Mental Hygiene. 'is marked other than "natural", or items 93a مر 98هـ و ملت 10a. State Director 1 Yes 2 No Union Bridge Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral U.S.A. 21791 10642 Green Valley Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc Armed Forces 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Specify: 1 ☐ Yes 2 X No Specify: Maryland 21215-0036 White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) construction master carpenter 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Marie Wolfe မ Edgar Flohr permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Union Bridge, MD 21791 10642 Green Valley Rd. Shirley A. Flohr/ wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Baltimore, 20a. Method of Disposition 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State nr. Libertytown, MD 12/9/2010 Chapel Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home Signature of Funeral Service License Woodsboro, MD 21798 Main St. 404 S. 23a. Part 1. Enter the disease, or complications that caded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant Year Month Day in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) certificate has been signed by the atte irector, page 2 should be detached for Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No JYes 2.□√N 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Impatient 2 ER/Outpatient 3 DOA 2 1 No မ heral Director: After this filled in by the funeral dir 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Certificate: work? 1 ☐ Yes 2 ☐ No 5 Pending 14 Natural Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a To the Funeral D Medical 29a. Certifier 3 L Certifying Nurse Fractioner To the Seat of my knowled a death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier MDH 64135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 W. Seventh St. Frederick, MD 21701 10 NIOSPIR State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10f, perfff, G910, 12/15/2010, WS

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#10f, perfff, G910, 12/16/2010, WS

Certificate of Death

Reg. No. O. J. O. Reg. No. O. J. O. Reg. No. O. J. O. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 8, 2010 Month Da DECEMBER Physician/ 1056 PM Grant Geneva Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMOR Agnes HOSPITAL eSAINT If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Months Hours Min Country) 1 □ M 2**X**□ F 94 Yrs. NC Director 09 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 □ No Baltimore NA MΠ 10g. Citizen of What Country? <del>1207</del>_21227 <del>1217</del> 10e. Street and Number 10f. Zip Code Funeral U.S.A. 2016 Northeast Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Black, White, etc. Armed Forces ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: Specify: Black 3 Wildowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Antique Dealer 2yrs 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ Hattie Smith Winston Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3526 Sussex Road, Baltimore, Md 21207 Elaine Grant-Daughter-In-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 12/17/2010 Owings Mills, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21215 ture of Funeral Service Licensee any in once, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BLREDING PEPTIC ULCER Immediate Cause (Final JASTROINTES TINAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical GRRR + GeneurDivision of Vital Records, P.O. Box 68760 Seneu IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death 5 Other (specify) a 🗌 Unknown ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Director: After this certificate 1 Yes 2 26. Place of Death (Check only one) filled in by the funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27, Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural
2 Accident
3 Suicide 5 Pending injury Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified DECEMBER 8, 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATTURS CHARLES CURTIS 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 Month 2010 Gloria Veronica Grandy 26 60 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6D Ridgebury Ct. Baltimore N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 F Months Days Hours 217-40-4129 67 03770371944 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A 1 X Yes 2 I No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6D Ridgebury Ct. 21244 S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 2 X No ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3X Widowed 4 ☐ Divorced Specify: Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry, Baltimore City (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Public Schools Cafeteria worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ezekiel Dunston Ruby Cager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Wheatley(son) 6D Ridgebury Ct., Baltimore, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 12/08/10 4 Donation 5 Other (Specify) Garrison Forest Owings Mills, MD 21. Signature of Funeral Service Licensee 2040 N. Hruft8WnAVE:, Bulleral Home 21217 ramo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (o a consequence of Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Month Dav Year 1 Yes 2 9 Unknown 4 ☐ Pregnant 9 ☐ Unknown tached Division of Vital Records, P.O. cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law autopsy performed? Yes 2 N 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending after death. Accident M 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cortifying Muria Fractionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 **To the I** 29b. Signature and title of cert icense number

State Registrar OHMH 17 Rev 7/2009 30. Name and address of

West Belvedore Avenue Bultimore Maryland

person who completed cause of death (Item 23a) (Type Print)

411

Physician/ **Medical Examiner** 

Funeral

any

Director

Funeral

þ

Completed

To Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

Director

1 X Natural

Accident

Suicide

Homicide 29a. Certifier (Check only one)

29b. Signature and title of certifier

2

3

Pending

Investigation

30. Name and address of person who completed cause of death (Item 23a)

OCME

Could not be determined

	e or Print in							gible			33899
1- For State	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		tificate d				_	lam Na	C_ U	10	00000
Registrar  1. Decedent's Name (First, Middle	,Last)					-1	2. Date of Dea	leg. No.			Time of Death
MARIA M. GIORO	ZAKTG						Month Decembe	Day	Year		0511 hrs
4a. Facility Name (if not institution	, give street and num	ber)		4b. City, Town, o	Location of	Death	Decembe		. County of	f Death	
6403 Doral Drive Apt. B	3			Baltimore					N/A		
Social Security Number	6. Sex 7	. Age (In yrs. Ia	ast birthday)	If Under 1 Yea	ar If Under	24Hrs.	8. Date of Bi	rth (MM/			hplace (State or
Usual Residence of Decedent		140 00									
MD 10b. County 10c. City, Town or Location BALTIMORE											10d. Inside City Limits 1 X Yes 2 No
10e. Street and Number			<del>.</del>	10f. Zip Code			11	Og. Citi	zen of Wha	at Cour	try?
441 GUSRYAN STE	REET			21224					S.A.		
11. Marital Status 1 X Never Married 2 Mar 3 Widowed 4 Divor		dent Ever in U. ces? 2 💢 No		/as Decedent of Hi Yes, specify Cuba	n, Mexican, F			)-	White,	etc.	can Indian, Black,
15. Decedent's Education (Specif	or Dates:	completed)	16a Decede	ent's Usual Occupa		ad of w	ark dono	1465	Specify: [		
Elementary/Secondary (0-12)	College (1-4		during	most of working life	. DO NOT us	se retire	ed)	IOD. F	(ind of Bus	mess/ir	idustry
Liementaly/oecondary (0-12)	4 YEARS	1015+)	SOCT	AL WORKE	₹			В	ALTIM	ORF	CITY
17. Father's Name (First, Middle, L				I		Name (	First, Middle, I				
MICHAEL G. GIO							LIA KON		,		
19a. Informant's Name/Relationshi				ng Address (Stree					ty or Town		Zip Code)
VENAGELIA GIORO  20a. Method of Disposition	JAKIS	Laon D				ALI.	IMORE,				-
1 X Burial 2 Cremation	3 Removal from		rematory or o	sition (Name of ce other place)	metery,		Date	20c. i	_ocation - (	Jity or	Fown, State
4 Donation 5 Other Spe		OAI	CLAWN (	CEMETERY		12/8	3/2010	В	ALTIM	ORE	, MD
21. Si matu e in Funer I Service Li	icensee		I C	Name and Address HARLES S 224 EAST	. ZEIL					m	21224
23a. Part Enter the disease, or co	omplications that cau	sed the death.	Do not enter	the mode of dying,	such as card	diac or	respiratory arr	est, sho	ck, or hear	t	Approximate Interval
failure. List only one cause of Immediate Cause (Final disease	a. Hyperte			sclerotio	Card	iova	ascular	Di	sease	:	Between Onset and Death
or condition resulting in death)	Due to (or as a c	onsequence of	):								
Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onsequence of	):	<u> </u>			-				
(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of	):			-	_		-		
<u> </u>	d										
X UNPENDED	AMENDED 2	3a,pt.	II,27	per me g	912 2-	4-1	vt				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ✓ Yes 2 ☐ No 9 ☐ Unknown	1 Live birt	nt at time of dea	2 🗸 F	etal death 3 other (Specify)	Ectopic p	regnan	су		Date of domenth	D	ay Year
Part II. Other significant condition	ns contributing to d	eath but not re	sulting in the	underlying cause (	jiven in Part	l.	23e. Did to	bacco u	use contribu	ute to ti	ne cause of death?

**Physician** /Medical Examiner

signed by the attending physician and be detached for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should

Examiner Medical Certification

Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy  1 Live birth  2 Pregnant at time of death  5 Other (Specify)  9 Unknown	23d. Date of delivery  Month Day Year  Dec 4, 2010
by	Part II. Other significant conditions <u>Diabetes Melli</u>		cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Completed		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1  Yes 2  No
a	25. Was case referred to medical	26.Place of Death (Check only one)	
To B	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Res	sidence 6 🗸 Other: Scene
Ë	27. Manner of Death	28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how	injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Yes 2 No

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

28f. Location (Street and Number or Rural Route Number, City

December 4, 2010

29d. Date signed (Month, Day, Year)

Donna M. Vincenti, MD 31. Date filed (Month, Day Year) State Registrar

Registrar's Signature

Assistant Medical Examiner

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Baby Girl Haase 0506 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Maryland (enter Baltimore 01 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month Day, DEC 3, 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 💢 F Hours 02 Min 01 Mary land Director infant Usual Residence of Decedent , or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 USA 1810 Bolton Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 24 No
If Yes, Give Black, White, etc. 1 🛮 Never Married 2 🗆 Married Completed by Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, ti onoe. Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ည Jessica Haase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) University of MD Medical Ctr 22 S. Greene Street Bsltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🖾 Other (Specify) in state Ronald State Anatomy action 655 W. Baltimore Street 21. Sign dure censee . Wade Baltimore, MĎ 21201 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ck, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Premature Preferm Fuoture Membrane (Internterine Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \( \subseteq \text{Yes} \) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 L No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 2 902031040 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Baltimore, MD 22 5. Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 0 2010

DHMH 17 Rev 7/2009

Registrar

# Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

			Pleas	e Type or Prin						-		_	ible.			
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Funeral Director		5. Social Security N 215-48-7		3. Sex 7. Ag	e (in yrs. i	ast birthday) Yrs.	Months	Days	Hours Min.	(Month, Da	ay, Year	5	Virg	untry) ginia		
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withii iene. than	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12 College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4															
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Ald be Aenta rked tic ev	Tr. Father's Name (First, Middle, Last)  George Paul Lottich  18. Mother's Name (First, Middle, Maiden Surname)  Elizabeth Smith															
shou and h is ma		19a. Informant's N							and Number or Ru							
and and and m 27 m 27 ner tr				h/daughter					ge Road l							
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If the Z7 is marked other than "natural", or items Z3a or 28a-f show any injury or other traumatic event, If a Macinal Examination is the rediffical all once.		20a. Method of Dis 1 Burial 2		B ☐ Removal from State	20b. P	lace of Dispo emetery, cren	sition (Nar natory or o	ne of ther plac	ce)	Date	20c. L	_ocation	- City or	Town, State		
t. Partmen rtmen rtant:	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee Ronal of S, Wades Director  22. Name and Address of Facility STate Anatomy Board 655 W. Baltimore St															
permi Depa Impo any ir		21. Signature of Ei	ons Lo S	Wades Dir	ector						V. B.	alti	more	Street		
_		23a, Part 1 Enter t	the disease, or c	omplications that caused	the death	n. Do not ent	Baltin er the mod	<b>nore</b> le of dyir	MD 212 ng, such as cardiac		arrest,			Approximate		
Physician		Immediate Cause	(Final	nly one cause on each li		F.	·luse	>						Interval Between Onset and Death		
/Medical		disease or condition resulting in death)	on	Due to (or as	a consequ		1016							years		
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The law requires that the death certificate ate has been signed by the attending physicage 2 should be detached for use as the t	Physician/Medical	in the past 12 1 ☐ Yes 2	<b>⊡</b> ∕No	4☐ Pregnant a			Other (sp					M	lonth	Day Year		
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ysici is cer direct	To Be	examiner? 1 ☐ Yes 2 ☐	146	Hospital: 1 ☐ Inpati	ent 2 🗌	ER/Outpatier	nt 3 🗆 D0	Oth	er: 4 \sum Nursing H			6 🗆 01	ther (Spe	cify)		
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or Att	27. Manner of Death  1 Natural  28a. Date of Injury  (Month, Day, Year)  28b. Time of Injury at Work?  1 No Accident  3 Suicide  4 Homicide  28b. Place of Injury - At home, farm, street, factory, office  28c. Injury at Work?  1 No Yes 2 No  28c. Digrate How injury occurred  28c. Digrate How injury at Work?  28c												ural Route Number,			
To the Hospital or Attending Physician; The within 24 hours after death.  To the Funeral Director; After this certificate completely filled in by the funeral director, pag		29a. Certifier (Check only	1 Certifying	Physician: To the best xaminer: On the basis of	of my kno	wledge, deat	h occurred	at the ti	me, date and place	e, and due to the	e cause(	(s) and r	manner as	s stated.		
the H thin 24 the F mplete	Medical	one)	d title of a saliti	waminer: On the basis of and manner st	ated.		20.01	Licor	o number		204 5	into sian	od (Mart	h Day Vear)		
<b>₽</b> ≅ <b>₽</b> ⊠		29b. Signature and	or certifier	/			29	// V	00676	(4)	230. 0	are sign	)	h, Day, Year)		
•		30 Name and add	ress of person "	rho completed cause of o	death (Itom	n 23a) (Tvne	Print\	NO	00065	- 0	1 6	- 6	- od			
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Sta		31. Date filed (Mor	nth, Day, Year)	32. Registr	rar's Signa	ture										
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ec Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 28,1953 **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Hours Massachusetts 57 024-44-8435 **Director** Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore City 1X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 721 St. Paul St. 21202 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 X Divorced Completed White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Abstractor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph S. Harvey Eleanor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise H. Liebowitz / Niece 4565 Macarthur Blvd. Washington D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 and Department of H 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4XX Donation 5 ☐ Other (Specify) Important: I any injury or Uniformed Sers. Univ. 12/8/2010 Bethesda, MD Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 21. Signature of Funeral Service 20910 xollum 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ 50 disease or condition resulting in death) Medical Due to (or as a consequence of) ¹Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 | Yes 2 a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe hours after death. neral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2  $\square$  No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title o 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aggie Savan Harshaw-Wynn December 15:35PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PG Prince Georges' Hospital Cheverly If Under 1 Year If Under 24 Hrs. . Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 😾 F (Month, Day, Year) **Director** 577-70-9249 62 Washington 17-1948 Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Suitland X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3940 Bexley Place #312 20746 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 5 ģ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Special Police Officer Gov't D.C. vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental item 27 is marked o Page 1 and 2 should be Fred Harshaw Aggie Streater 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward C. Wynn - Husband 3940 Bexley Place #312; Suitland, MD 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oti Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cem. 12/17/2010 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services Flemour 4594 Beech Road; Temple Hills, MD 20748 23a. Par 1. Enter the disease, or commitications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory irrest shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onse and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequ Examiner Gaquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month ☐ Pregnant at time of death☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 10 Natural 5 Pending s after death. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. December

Registrar

State

Muce

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2:15 P.M Henderson December Katherine 8 2010 Mary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Frederick Villa Nursing & Rehab Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 212 F Months Days Hours Min 026-24-2557 Director 80 Sept.10.1930 Massachusetts Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits ral", or items 23a or 28a-f show Director 1 Yes 21 No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P. O. Box 5 21146 USA Funeral e filed within 72 hours after death all Hygiene.
other than "natural", or items 23: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No Specify: \$ Specify: White 3 ₩ Widowed 4 □ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Massachusetts Library Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of and 2 should be James Patrick Kelly Eva Marian Rogerson ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 240 Arundel Beach Road; Severan Park, MD 21146 Brooke Henderson Daughter permit, Pages 1 and Department of Healt Important: If Item 2: any Injury or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 12/9/2010 Atlantic Crematory 4 Donation 5 DOther (Specify) Glen Burnie, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Sign ture of Funeral Service 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vasive **Physician** YY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off that the death certificate be executed pue Due to (or as a consequence of) burial physician the burial Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 1 Yes Ö 9 I Inknown signed by t ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 2- No 1 ☐ Yes 2 ☐ No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural Injury 5 Pending within 24 hours after occur.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Hospital 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URAKUNA 1009, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 0 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 450 M HUECHINSON 2 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 40 County of Death **Examiner** BALLIMORE MANORCARE TOWSON TOWSON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 8,1922 **Funeral** Days Ohio 1**反** M 2□ F Hours 290-14-9820 88 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Indical Ever. In the public anone. 10c. City, Town or Location 10d, Inside City Limits 10b. County t∩a. State Nottingham Maryland Baltimore 1 ☐ Yes 2 ▼ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4300 Cardwell Avenue #204 21236 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗓 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative MD Business Forms 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas B. Hutchinson Leah L. Bone ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Helen H. Hutchinson (Spouse) 4300 Cardwell Avenue #204 Nottingham, MD 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition December 13 1 Burial 2 □ Cremation 3 □ Removal from State Parkville, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, Maryland 2 gnature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the shock, or the t failure. List only one cause on each line. Parkville, Maryland 21234 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ending physician and use as the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical led by the attending detached for use as IF FFMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown rcare has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≥</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 🗆 No 1 □ Yes 2 -No 1 ☐ Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and tille of certifier 29c. License number R158140 WAlthAN Woods,

DHMH 17 Rev 1/2001

State

Registrar

PRODUCA

31. Date filed (Month, Day, Year)

110

parkel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hirshauer Patricia Beatrice 2010 December 5:00 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Harford Abingdon 1417 Calvary Road Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth

(Month, Day, Year)

Dec 6, 1916 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2🛣 Months Hours Min 94 Pennsylvania **Director** 220-34-7096 Usual Residence of Decedent than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1417 Calvary Road 21009 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Machine Operator Shoe Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna (nmn) Klecka James (nmn) Pouska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia F. Harmon / Daughter 1419 Calvary Road, Abingdon, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gdn. 12-11-10 Air Bel Air, Maryland 21. Signature of meral Septice Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or coopling nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Approximate Interval Between Onset and Death shock, or heart failure, List only Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit CEREBRAL and that initiated events resulting in death) Last Due to (or as a consequence of attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year the 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check hin 2 only one 29b. Signatur 29c. License number D46667 2010

Registrar

SYEDAH.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

32. Registrar's Signature

2227

OLD EMMORTON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. GILANI, M.D

BELLIR, MO 21015

SUITE 212

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 6, 2010 6:52 A M Catherine Vivian Hagner Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 710 O'Brecht Road Sykesville Carroll County Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕅 F July 4, Year) 918 Days Hours Country Maryland **Director** 215-03-2333 92 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director

Hanover

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No

1 ☐ Yes

Year or Dates

College (1-4 or 5+)

10f. Zip Code

17331

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

20b. Place of Disposition (Name of

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Adams

15. Decedent's Education

(Specify only highest grade completed)

1337 Pine Grove Road

1 Never Married 2 Married

3 X Widowed 4 ☐ Divorced

Elementary/Seconday (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type, Print)

Catherine Benner-Daughter

Anton Volkman

20a. Method of Disposition

10e. Street and Number

Funeral

Completed by

Be

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1 Yes 2 V No

10g. Citizen of What Country?

14. Race - American Indian Black, White, etc.

Specify: White

20c. Location - City or Town, State

NO 21157

16b. Kind of Business Industry

Own Home

18. Mother's Name (First, Middle, Maiden Surname)

Irene Shanks

1337 Pine Grove Road, Hanover PA 17331

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

Westminster

USA

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must han access to once. Baltimore, Maryland 21215-0036

> Physician/ Medical **Examiner**

and -tran: Division of Vital Records, P.O. Box 68760 certificate ha the Hospital or Attending thin 24 hours after death.

	1 XBurial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		rematory or a	other place) Cemeter	•	10,2010 B		Maryland
	21. Signature of Funeral Service Licensee	Con	2			•	ose Funer Road Arb		Inc. cyland 21227
lical Examiner	23a. Part 1. Enter the disease, or complical shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last  d.	ause on each line.	Sclere sequence of):				espiratory arrest,	iseasc	Approximate Interval Between Onset and Death
by Physician/Medical	in the past 12 months?	If yes, outcome of pre 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3 of death 5	Ectopic Other (s	pecify)	rt I.			Day Year  of the cause of death?
completed							24a. Was an autopsy performed?	24b. Were au prior to death?	ntopsy findings available completion of cause of
o l	25. Was case referred to medical				26. Place of De	eath (Check or	•		
0	examiner? 1  Yes 2 No Hosp	oital: 1  Inpatient 2	FR/Outpat	ient 3 🗆 D	Other:	Sureina Hama	5 Residence	€ □ Othor (C===	16.1
rificate; I	1 Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	28a. Date of injury (Month, Day, Year	28b. Time	of 2	28c. Injury at work? 1 ☐ Yes 2	286	d. Describe how inju		
3	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, s ecify)	street, factor	y, office	28	f. Location (Street a City or Town, Sta		ral Route Number,
Medical	29a. Certifier (Check (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one	On the basis of examina	ation and/or inv	estigation, in	my opinion, death	occurred at the	e time, date and place	ce, and due to the	cause(s) and manner stated.
	29b. Signature and title of centifier			290	D437	-		ate signed (Monti	

DHMH 17 Rev 7/2009

State

Registrar

TARIW

31. Date filed (Month, Day, Year)

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Kuad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38908 For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 24 a.M Nancy A. Hooker ecembe Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Da HIMOR If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) Funeral 8 Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year 11/18/47 1 🗆 M 2 💢 F Months Days Min. Mary land Yrs. Director Usual Residence of Decedent 28a-f shov 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD **Baltimore** Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4313 Wilkens Ave 21229 USA should be filed within 72 hours after death vand Mental Hygiene.
is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify. Completed 3 Divorced 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 injury or other traumatic <u>John Joseph Hooker</u> Dorothy Edna Thompson and 2 should b Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4313 Wilkens Ave. permit, Page 1 and 2 Department of Health Important: If item 2; any injury or other the Dorothy E. Paul / Mother Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Baltimore Crematory 12/10/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 6 23a. Part 1. Ent / the disease, or shock, or reart failure. List mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, may one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ unobeations disease or condition MANUIN Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Choking on bolus of food Hospital or Attending Physiclan: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No DERTIFICATIO! Ectopic pregnancy Month Day Pregnant at time of death Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy perform 2. No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗌 No Other: 1 Yes Certificate: To 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred **Choked on food** work? 1 ☐ Yes 2 🗶 No Natural 5 Pending 12/07/2010 n 24 hours and ne Funeral Director: A 2 Accident 8:00 Investigation 6 Could not be Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Home** 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4313 Wilkens Ave., Apt. B, Baltimore, MD determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, dead occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed dause of death (Item 23a) (Type, Print) 2122 Day 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER Physician/ 5.55 2010 KAYMOND Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE Social Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 9/128, Pay4 Year) Months Hours Min. Mary land 212-20-7170 86 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** 1 ¥ Yes 2 ☐ No MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1907 W. Lombard Street 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Administration Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth I Whitmore Herman A. Horz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7737 Notley Road Pasadena, Maryland 21122 Mr. Harry M. Horz Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 12/11/10 4 Donation 5 Other (Specify) Loudon Park Cemetery Baltimore, Maryland 21. Signature of Euneral Service Libensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ Stroke days Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Disa to (bridge a consection of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗹 No Other: ျ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, within 24 hours after death To the Funeral Director

Registrar DHMH 17 Rev 7/2009

State

(Check

only one) 29b. Signature and

GOVIL

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERN AVENUE

32. Registrar's

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES-000

BALTIMORE MD 21224

29d. Date signed (Month, Day, Year)

2010

DECEMBER 8

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Physician/ November 10, 2010 10:10 aM Israel Emmanue1 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery Kensington Nursing & Rehabilitation Kensington 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Sept. 5, 1928 1 X M 2 🗆 F Hours Washington 82 534-26-7549 **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 🗌 Yes 2 💆 No Kensington MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20895 3000 McComas Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. Armed Follows.

1 🖾 Yes 2 🗆 No fter
If Yes, Give 1951 1 Never Married 2 Married ð White 1 ☐ Yes 2XXNo Specify: Specify: 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Crain Operator Salvage Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file h and Mental F is marked of Cleta Ruth McCluer 2 Clarence Dick Leenders other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2441 Yew Street Rd. Bellingham, Washington 98229 19a. Informant's Name/Relationship (Type, Print)
Russell Leenders permit. Page 1 and 2 sh
Department of Health ar
Important; If item 27 is
any injury or other trau (son) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory Dec Date 10 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2010 Beltsville, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signature of Funeral Sarvice Licenses M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Unknown Immediate Cause (Final Atherosclerotic Cardiovascular Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Be Completed by Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ned by the a 9 Unknown 9 Unknown signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypertension peen 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an Dementia autopsy performed? Yes 2 No page 2 Adult Failure to Thrive 26. Place of Death (Check only one) 25. Was case referred to medical director, examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital 1 ☐ Yes 2XXNo 1 Inpatient 2 ER/Outpatient 3 DOA ျ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident
3 Suicide
4 Homicide n 24 hours after death

• Funeral Director: A

pleted filled in by the f Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

JA

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

State Registrar Nurul Chowdhury, M.D. 1.

31. Date filed (Month, Day, Year) 32. Registrar

low de

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

32. Registrar's Signature

within 2.

To the Foundation

29c. License numbe

15216 Dino Dr. Burtonsville, MD 20866

D43121

29d. Date signed (Month, Day, Year)

December 9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Christine Renee Imhoff December 06. 2010 04:20 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford County If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Days Hours Min April 18, 268-68-9602 46 Director Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Tes 2 No Maryland Harford County Edgewood 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 2422 Hanson Road Apt. 88 21040 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 0 Completed by 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Tes 2 X No Specify: 3 Widowed 4 Divorced Specify: White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 Own Home is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Philip Elsass Helen E. Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James L. Imhoff 2422 Hanson Rd. Apt. 88, Edgewood, Maryland 21040 other 1 20a. Method of Disposition 20b. Place of Disposition (IVALIDADE) cemetery, crematory or other place)
Evans Funeral Chapel
Bel Air 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5 Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Dec. 4 ☐ Donation 5 ☐ Other (Specify) 2010 Forest Hill, Maryland of Funeral Service Licensee Jeffrey R. Testerman May R Sullanum (M01543) 22. Name and Address of Eacility Evans Funeral Chapel & Cremation Services - Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Probable disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, If any, leading to mimediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Day 2 🗆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
Yes 2 \sum No Hospital Other: ျ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending **Division**¹ work Accident Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print osań Birnbaum. m. D. 500 U

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Susie Anna Jefferson 7:25 p M 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Joseph Ritchie Hospice Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 TTA **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days (Month, Day, Yea 2/16/25 85 231-22-2226 1 M 2 TVF Director VA Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director N/A Baltimore MD 1 ¥ Yes 2 ☐ No 10f. Zip Code 21223 10e. Street and Number 10g. Citizen of What Country? Funeral 229 N. Mount St USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Completed by Maryland 21215-0036 African 1 ☐ Yes 2X No Specify: "natural" 3 XWidowed 4 Divorced Year or Dates Amer the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Self Elementary/Seconday (0-12) College (1-4 or 5+) 10 Dom. Engineer other permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H 7 is marked ott Willie Young Mattie Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lelia Mae Rollins/Daughter 1607 Rutland Ave, Balt.MD 21213 Page 1 and 2 Baltimoré, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/15/10 Garrison/Owings MD Garrison ForsetVA 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Funeral S / ice Licensee 22. Name and Address of FacilityHari P. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical uence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregpant 23d. Date of delivery 3 🗌 Ectopic pregnancy or Attending Physician: The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Record 246. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page ✓ Yes Yes 25. Was case referred to medical Division of Vital Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral E Hospital of the Hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Monty, Day, Year) State Registrar

DHMH 17 Rev 7/2009

1

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

illiam Jenkins		1-For State  State of Maryland / Department of Health and Ment  1-For State  Certificate of Death	aı Hygien	е	2010	38913
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eulcai Exaiii	nei	William Harvey Jenkins  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of		ember 29	4c. County of Deat	
		1300 East Lanvale Street Apt.227  Baltimore	Death		N/A	'
Euparal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	24Hrs. 8. Dat	e of Birth/M	M/DD/YYYYY 9. Bi	rthplace (State or
Funeral Director		Months Days Hours	Min.	`	Forei	an .
		220-38-7784 1 M 2 F 68 Yrs. 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1 Says 1	0	7/07/	1942	ountry) MD
any		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits
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aryland 8a-f show at once.	tor	MD N/A Baltimore  10e. Street and Number 10f. Zip Code		100.0	Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once.	Director					ilia y :
ith th 23a c		1300 E. Lanvale St. 21201  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Status	in 2 / Consider Vo		I.S.A.	ince Indian Disek
ath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican,			White, etc.	ican Indian, Black,
er de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:			Specify: B1	ack
irs aft ural	ð	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give ki	ind of work done	e 116t	b. Kind of Business/	
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thin 7	ğ	12th Grade Laborer		M	lanufact	uring
5-0036 ed within 72 h tygiene. other than "n	Compl		Name (First, M	fiddle, Maide	en Surname)	-
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be (	James A. Jenkins Ed	dna Gro	oss		
D 21 hould nd Mei is man	ပ္	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number)	per or Rural Rou	ıte Number,	City or Town, State	e, Zip Code)
		Phyllis Arrington(sister)   570 McManus Way	y, Tows			
Te, 1 and 1 Heal		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery,	Date	20	c. Location - City or	Town, State
Pages ent of		1 Burial 2 Cremation 3 Removal from State Josephor Brown F/H 4 Domation 5 Other Specify: ANd Crematory	12/07	/10 E	altimor	e,MD
Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum.		21, Signature of Funeral Service Licensee 22 Name and Address of Fecility.				
E P P E	1 0	21. Signature of Funeral Service Licensee 22 Name and Address of Facility 2140 N. Fulto	n Ave	.,Bal	timore,	MD 21217
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cal failure. List only one cause on each line.	rdiac or respirat	tory arrest, s	hock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease				Death
Examine		or condition resulting in death)  Due to (or as a consequence of):				
		Sequentially list conditions, b.				
	ig.	if any, leading to immediate Due to (or as a consequence of):				4
	E	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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68760, certificate be executed nding physician and	Medical Examiner	UNPENDED AMENDED				
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		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, M</li> </ol>	D 21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Margaret Mary 701 AM Jachelski 12 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Rosedal Ballimore FRANKLIN Sauare HOSPITal Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2**X** F Min. 12/21/1930 Marvland Director 218-26-9302 Usual Residence of Decedent margaret 10a, State 10b. County 10c. City, Town or Location death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 202 George Avenue 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. ð 1 Never Married 2 Married should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Yes 2 X No Specify: Specify: Completed 3 № Widowed 4 □ Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Henry Dohler Frances Friedel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Herpel (Daughter) 202 George Avenue, Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory, Inc. 12/10/2010 | Baltimore, Maryland 21. Signature of Foundation Solving Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. <u>1407 Old Eastern Avenue, Essex, Maryland 21221</u> 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End or an Due to (or as a conse Pence of): dix ase or condition resulting in death) an Medical Examiner Intervascular Coagulation Disseminated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence on arte has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? this certificate 2 No 2 1 1 🗌 Yes Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this nontified. completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🗷 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse/Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BaLTO 9000 FRANKLIN Square DR md ALA Ahmad 32. Registrar's Signature State Registrar

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			5. Social Security No.	Topkir	6. Sex					coeting				
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A			Usual Residence of	Decedent							12-10	1-1931		MD
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ De l'ember Year Hagar L. Johnson 02:00 Q-M 7010 Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death eal VR 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 😿 F Hours Min. May 27, 1925 Virginia 85 **Director** 218 - 26-9649 Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits N/A 4011 Wilkens Ave., Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4011 Wilkens Ave. 21229 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Turner Violet Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony J. Johnson (Son) 4011 Wilkens Ave., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Loudon Park Cemetery 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/9/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilityLoudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Eater the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TRACT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Dust to for as a consequence of: cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Day Year ed by the a detached f 9 Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 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Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 s After this certificate har funeral director, page 1 Yes 2 No Yes 2 N å 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: ြုင 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ↑₩ Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, J.O. Box 68760 neral Director: A within 24 hours a

To the Funeral C

D0061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 WILLOWS AVE #307 BALT. KUD 2122 an could

State Registrar

Medical

29a. Certifier (Check

only one) 29b. Signature and titl

31. Date filed (Month, Day, Year, 32. Registrar's Signature 2010

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10-09256 Aaron Kelley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Aaron Kelley		1- For State	state of Maryla		artment o <i>rtificate o</i> :		nd Menta		201	0 38917		
Physical Exam		Registrar  1. Decedent's Name (First, Mid Aaron		Kelley			-,-	2. Date of Dea Month	Day Year	3. Time of Death		
Medical Exam	iner	4a. Facility Name (if not institut		•		4b. City, Town,	or Location of I	Decembe	r 2, 2010 4c. County of D	1147 hrs		
		Sinai Hospital			_	Baltimore			NA			
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday) Yrs	Months Da	ear If Under 2	10 - 10	Birthplace (State or Foreign Country) MD			
any		Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	, Town or Locat	ion				10d. Inside City Limits		
	ō	MD	NA	Ba	ltimor	e				1XXYes 2 No		
with the Maryland ns 23a or 28a-f sho be notified at once,	Director	10e. Street and Number 5344 Cordel	ia Avenue	e		10f. Zip Code 212		1	0g. Citizen of What 0	Country?		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	/ Funeral	11. Marital Status 1 Never Married 2 1 3 Widowed 4 D	Married Armed Fo	2 🔀 No	If Y	is Decedent of Hes, specify Cub	an, Mexican, P	- 14 Race - American Indian, Black, White, etc. African Specify: American				
ours af satural	d by	15. Decedent's Education (Sp		le completed)	16a. Deceder	it's Usual Occup	ation (Give kin		16b. Kind of Busine			
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat	Completed	Elementary/Secondary (0-12 Child	N A	,	Chi				Child			
215-(e filed red of the orth	Be Co	17. Father's Name (First, Middl Kennard	e, Last) Watkin	ns			18.Mother's P	Name (First, Middle, I N∵V	Maiden Surname) Kell	Lev		
7 P P P P P		19a. Informant's Name/Relation					eet and Numbe	r or Rural Route Nun	nber, City or Town, S	tate, Zip Code)		
nd 2 s alth a		Darlene Br	own-Foste			Cord∈ ition (Name of c		venue Ba	lltimore	MD 21215		
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr		1 Burial 2 Crematic				ner place) n Cem.		12-08-10		owne, MD		
Baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Service		,		lame and Addre				Home P.A.		
-10	Ш	23a. Part I, Enter the disease, of	MILLE COMPLICATIONS that ca	yused the death						e, MD 21217		
Physician /Medical Examiner		failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	e on sach line.	n Infant	t Death					Between Onset and Death		
		Sequentially list conditions,	b									
	amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a									
cuted and transit	EX	events resulting in death) Last	d.									
O, be exe sician a	edic	X UNPENDED		23a,27		g913 3-	1-11 vt					
or att	Physician/M	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  **EX** UNPENDED**  UNPENDED**  IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Universed.	1 Live bi	ant at time of de	2 Fe	tal death 3 ner (Specify)	Ectopic pr	egnancy	23d. Date of deli Month	very Day Year		
O. B. hat the de ed by the etached f	by Ph	Part II. Other significant cond	tions contributing to	death but not re	esulting in the u	nderlying cause	given in Part I			to the cause of death?		
Is, P.C quires that en signed	ted	-						1Yes		Probably 4 Unknown autopsy findings available		
of Vital Records, R Physician: The law requir then this certificate has been s meral director, page 2 should	Completed							autop perfor 1 ✓ Yes	sy prior med? death	to completion of cause of		
Vital hysician: this certi	Be	25. Was case referred to medic examiner?		patient 2	ER/Outpatient		Other		Residence 6 0	ther:		
Sion of \ Stending Phy r death. ector: After th by the funeral C	tion: To		28a. Date of (Month,		28b. Time of Ir	njury 28c. Inj	ury at Work?	28d. Describe h	now injury occurred			
를 다 다 다 드	Sertification:											
To the Hospital within 24 hours. To the Funeral completely filled	Medical	1-11-11	Physician: To the best aminer:On the basis or and manner sta	f examination ar					, .			
* * * * * * * * * * * * * * * * * * * *	ž	29b. Signature and title of certif					se number		29d. Date signed (December 3, 2			
Line I	ı	30. Name and address of perso	who completed cause	,		Street, Balti	imore MD	21201	1			
		31. Date filed (Month, Day Year,		gistrar's Signatu								
Regis	trar	DEC	I U ZUIU	Querra	1. S.	arkel						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER Day 8 20 To KATS 2:25 A M LIDIA Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 4c. County of Death MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Country) 1(2717791919 Director 057-62-9983 90 UKRAINE Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral 23a 4204 OLD MILFORD MILL ROAD 21208 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black White etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ▼ No Specify: Specify Completed 3 Widowed 4 XDivorced WHITE Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **FOOKS** NINA SCHNEIDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5607 NEWLAND PLACE, FT. WAYNE, INDIANA ALEX BABICH/NEPHEW 46835 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Donation 5 Other (Specify) HILLTOP SERVICE CORP : 12/9/2010 TOWSON, MD Sign ure f Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. 10 not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death men en Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a No Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> seas Records. 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy perform certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Sursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injurv Matural 5 Pending work? 2 🗌 No n 24 hours after death e Funeral Director: A bleted filled in by the fu 2 Accident 3 Suicide 4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie

State Registrar

DHMH 17 Rev 7/2009

within 2 To the F

(Check

only one

29b. Signature and title of certifie

CDS 31. Date filed (Month, Day, Year)

32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ tonth 36 ZION ANTOINE LEACOCK - WIAL -KER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OSPITA SILVER SPRING CROSS MONLCOWER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 M 2 D F Director Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No BOWIE PUND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 207 5 DUNMOOD VALLEY 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black White etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♠ No Specify: "natural", 3 Divorced 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 1 WAY W) TURANT M Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WALKER ANTOINE RONNELLE OFLIA LEVIC permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLY CROSS HOSPITA! FOREST NB10 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 □ Denation 5 🛛 Other (Specify) in state Sig tur of Funera 3 n Rona I State Andresmy aboard 655 W. Baltimore Street censee Director un 21201 MDBaltimore, Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician 10, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events HORIOAMNIONIT attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 1 Yes 2 No Yes 2 🛝 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 13/10 မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No death. 2 Accident
3 Suicide Investigation fter death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours Medical 1 The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse fractioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of cer 29c. License number 30. Name and address of pirson who completed cause of dear (Item 3a) (Type, Print)

Registrar

State

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2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend 5 per A.B. g912 2/4/10 ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month PM HINE EACOCK-WAL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CROSS JA R 6 KION OUTGOMER Social Security Number 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days A **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b County 10c. City, Town or Location 10d. Inside Çity Limits Director 1 Yes 2 No PG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral SV VAL DUNNWOOD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 M No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates _Q 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) INFA MEAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည RAC MIGTM RONNELLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FOREST CROSS HOSPITA 200 GLEN 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☑ Other (Specify) in state Sign thue of Funeral Service Licenses 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street rector 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OH disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, local good intercept cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Tue to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit HORI DAMNIONIFI Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3[ Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Day Year Pregnant at time of death funeral director, page 2 should be detached g Unknown g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: ဂ္ 1 🗌 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural (Month, Day, Year) injury 5 Pendina ☐ Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CWI FOREST RD 5.2. MD 50910

State Registrar 32. Registrar's

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6,2010 December Tamira Denise Lyles Medical Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital of Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 XF Hours 02/27/1990 Director 217-27-3137 20 Usual Residence of Decedent 28a-f show 10a, State 10h. County 10c. City, Town or Location Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified N/A Atlanta MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Denise Lyles Funeral 2745 Old Hopeville Rd. 30354 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xio If Yes, Give Baltimore, Maryland 21215-003 1 ☐ Yes 2X☐ No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A 12th Grade Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Lolita Tripp Michael Lyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2745 Old Hopeville Rd., Atlanta, GA 30354 Michael Lyles(father) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 12/11/10 Baltimore, MD 4 Dopation 5 Other (Specify) King Mem. Park 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD Þ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ alveolar hemorrhage disease or condition resulting in death) Medical Examiner vthematosus Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Law maral Director: After this certificate has been signed by the attending physician and ever filled in by the funearal director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? hemolytic anemia 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown end stage renal disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an erformed? 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospita Other: _2 🖪 No 잍 1 🗌 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) injury 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number RES-000 MDPHD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rachel Hallmark MD PhD Hospital of Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10:42

9. Birthplace (State or Foreign

10d. Inside City Limits

PA 21217

Onset and Death

30 minutes

vears

Year

Day

1 Yes 2 No

1 Yes 2 X No

Maryland

Black, White, etc.

Month

DHMH 17 Rev 7/2009

Registrar

strar's Signature Enewa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death t's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ INIO Medical City, Town, or Location of Death **Examiner** 4c. County of Death last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 Months Days Hours Min Director or items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location by Funeral Director Yes 2 ☐ No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian Armed Forces?

1 Yes No
If Yes, Give
Year or Dates. Black White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) an//3 edo (day (0-12) Callege (1-4 or 5+) Stome Be 17. Father's Name (First, Middle, Mother မ rug Lter 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, Cit 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) cemetery, crematory or other place) nature of Funeral Serv 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) ew ven yech Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year n signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an i 24 hours after deam.

e Funeral Director: After this certificate has learned of the continue of the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the following from the follow autopsy 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗆 No 1 Yes 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who

Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#22perFH. G910.12/10/2010, WS
State of Maryland / Department of Health and Mental Hygiene 20 | 0 For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year Day Month Physician/ M Δ 2010 8 - 47 Robert J. Lowry Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice 9. Birthplace (State or Foreign If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) (Month, Day, Year) 0-5-1947 **Funeral** Days Hours Min. Country) Months 1 DXM 2 □ F MD 63 Director 216-52-0374 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location or 28a-f show 10a. State 10b. County or than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1x Yes 2 No MD Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 8124 Delhaven Road 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates. Vietnam 1 Yes 2 XNo Specify: Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) pernit, Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) BGE Home Warehouseman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Eugene Lowry, Mary Townsend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dundalk, MD 21222 te 20c. Location - City or Town, State Mariana Lowry - Wife 8124 Delhaven Rd Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 12-8-10 Glen Burnie, MD 4 Donation 5 Other (Specify) Ashton Asahton Funeral Home 22. Name and Address of Facility
PA, 2134
Will 21. Signature 21 Fun Bradleyllow Spring Road 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition elics Pnysician/ 6lioblustoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Due to (or as a consequence of): Examiner burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Cenebravasular disease, coroneur 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an discous autopsy performed? Yes 2 DrNo 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 Yes 2 Yo Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Kother (Specify) to Spec Zf Hospital 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: injury 5 Pending X Natural Investigation Accident after death Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29d Date signed (Month, Dav. Year) 29b. Signature and title of certifier D0070 7235 MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cherry Co 701

State Registrar 32. Registar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /				Mental H	/giene	10	38924
			Registrar	Cer	tificate of L	Jeath		Reg. No.	10	30324
_	Physicia	. n	1. Decedent's Name (First, Middle, Last)	1 -	-		2. Date of D	eath Day	Year	3. Time of Death
1.0	/Medic		John F. Macdowoll		7-		12	06	10	7,33 AM
	Examin	-	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		eath	4c. Count	ty of Death	
			Loch Raven CLC		Bultin					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last in	birthday)	If Under 1 Year Months Days	If Under 24 H Hours M		irth lay, <i>Year</i> )	9. Birth	place (State or Foreign
Ь.	Director		095 <b>-</b> 32 <b>-</b> 9349	Yrs.	Months Days	Flouis W		1940		v YOrk
	D		Usual Residence of Decedent							
	ylan how at	,	10a. State 10b. County 10c. City, To	wn or Lo	cation					10d. Inside City Limits
	a-fs	Ş	MD Caroline	D	enton					1 □Yes 2 □ No
	h the	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of	What Cou	intry?
	h wil		501 Elaine AVenue		21	629		Ι	JSA	
	deat ms	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin?	(Specify Yes or N	lo- 14. Ra		ican Indian,
0	affer or ite	Ē	Armed Forces?  1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No				ierto Hicari, etc.)		ack, White,	
8	al',c	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 159—17	9	1 □ Yes 2 📉 No	Specify:		Spec	ify: WI	nite
9	2 ho	Completed	15. Decedent's Education	Sa. Deced	ient's Usual Occup	ation		16b. Kind of	Business/Ir	ndustry
<u> </u>	hin 7	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. I	kind of work done of OO NOT use retired	) )	working			
5	d with	E O		inte	lligence	agent		Dept o	f Arm	ny
g	be filed within 72 hours after death with the Marylan Ital Hyglene. It other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)			18. Mother's N	lame (First, Middi	e, Maiden Surna	ime)	
altimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	To B	John Frederick MacDowell			Eliza	abeth Te	cesa Sor	iano	
3	shound IV		19a. Informant's Name/Relationship (Type. Print)	9b. Mailir	ng Address (Street a	and Number or	Rural Route Num	ber, City or Tow	n, State, Zi	ip Code)
Š	4.7 ± d		Mary K. MacDowell/spouse	501	Elaine A	venue l	Denton, 1	MD 2162	.9	
ō,	permit. Pages 1 and Department of Health Important; If item 27 any Injury or other tr		20a. Method of Disposition 20b. Place	of Dispo	sition (Name of	)	Date	20c. Location	- City or T	Town, State
2	Pages nent of int; If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	негу, сгег	natory or other plac	e) ;				
Ξ	permit. Pages Department of Important; If il any Injury or e			22	Name and Addres	ss of Facility				
Ba	Depire Impo	ļļ	21. Sing ture of Funeral Service tyensee Ronald Si Wide Director	-	2. Name and Address ate Anato	-		. Balti	nore S	Street
		-	23a. Part Enter the disease or complications that caused the death. D	Ba	altimore,	MD 21	201	ownot		Approximate
b			shock, or heart failure. List only one cause on each line.			y, such as care	nac or respiratory	anesi,	- 3	Approximate Interval Between Onset and Death
	Physician		disease or condition	$D_i$	sease					unknown
	/Medical Examiner		resulting in death)  Du (to (or as a consequence	ce of):						
	LAdillilei	_	Sequentially list conditions, b.							
	₽ #	nei	cause. Enter Underlying	ce of:					-4	
	ocute nd trans	Examiner	Cause (Disease or injury that initiated events c.							
Ö,	e exe ian a ırial-	Щ.	resulting in death) Last Due to (or as a consequent	ce of):						
8760	cate be executed physician and the burial-transit	dical	d							
9	ng ph as th	Ned	IF FEMALE:							
ŏ	death certific attending p	J/ug	23b. Was decedent pregnant 23c. If yes, outcome pr pregnancy		Ectopic pregnancy	,			Date of deliv	
m	dea le att	Sicia	in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown		Other (specify)			, , , , , , , , , , , , , , , , , , ,	vionth	Day Year
<u>Ф</u>	that the de ned by the	Physician/Me	9 □ Unknown							
	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resulting	g in the u	nderlying cause give	en in Part I.	23e. Dio	ł tobacco use co	ntribute to	the cause of death?
ğ	quire in sig uld b	od b					_ 10	]Yes 2□No	3□ Pro	obably 4 Unknown
Records,	w require s been sig should b	Completed					24a. Wa	s an 24t	. Were au	topsy findings available
8	he lav e has ige 2	m d					— au pe	topsy formed/?	prior to co death?	ompletion of cause of
Vital	n: T ficate or, pa		25. Was case referred to medical				1□ Yes		1 ☐ Yes	2 □ No
5	sicia certi recto	Be (	examiner?	(O) to object	t 3 DOA Oth	or.	Death (Check only			
Division or	Physician: The la r this certificate has ral director, page 2	. To		Outpatier b. Time o	IL SELECT	4 LI Nursin	g Home 5 Re	sidence 6 ∐C e how injury occ		cify)
nc	ding I. After fune	io	1 Natural 5 Pending (Month, Day Year)	Injury	Wor	k? Yes 2 ⊟ No	200. Describ	e now injury occ	aned	
S	tten death stor: / the	ical	3 Suicide 6 Could not be 280 Place of injury. At home	farm str		103 2 110	29f Location	(Street and New	mbor or Pu	ral Route Number,
<u> </u>	I or Attending after death. Director: After in by the funer	Certification:	4 Homicide determined building, etc. (Specify)	,	out, rectory, office			own, State)	iber or ria	rai Floble (Varibe),
	Hospital 24 hours a Funeral I	ŏ	29a. Certifier 1 Certifying Physician: To the best of my knowler	dae dest	h occurred at the ti-	ne data and -	lace and due to #	on called/e/ and	manna	etated
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier   Certifying Physician: To the best of my knowled (Check only one)   2   Medical Examiner: On the basis of examination and manner stated.	and/or in	ivestigation, in my c	ppinion, death o	occurred at the tim	e, date and plac	namer as e, and due	to the cause(s)
	To the H within 24 To the F complete	Med	29b. Signature and Attle of certifier		29c. Licens	e number		29d. Date sign	ned (Mon#	Day Year)
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				1	20	-5 /(		120	J 67	10
			30. Name and address of person who completed cause of death (Item 23	a) (Type,	Print)	D nen	10.	1 /	, .	
			John S: Lich mo, 3900 Loch Ray	en /3	valerand,	120251	mere, M.	9) 4/ and	21	218
	Sta Registi		31. Date filed (Month, Pay Year) 2010 32. Registrar's Signature	box	1			1		
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DHMH 17 Rev 1/2001

State

Registrar

Addo M.D.

32. Registrar's Signature 31. Date filed (Month, Day, Year)

ichard

30. Name and a dress of person who completed cause of de in (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #25, per ME 910 12/10/10 TT Trument of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🤈 2. Date of Death , Decedent's Name (First, Middle, Last) Day Month Year Physician/ ecembe VERONICA MANCIN Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Bay view Med Conter Johns demare Hopkins 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 **K** F Min. Months Hours 212-26-4421 Director Dec II. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director DUNDALK 1 🗌 Yes 2 🕱 No Marylmo BAltimere 10f. Zip Code 10g, Citizen of What Country? 5 10e. Street and Number 23a Funeral U-S-A 21222 'natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 ☐ Divorced or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOME OWN HOMEMAKER 11 Th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ndr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Typę, Print) 6749 item 27 Brother Joseph 20b. Place of Disposition (Name of Date 20a. Method of Disposition permit, Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 12-11-OAKLAWN 10 4 Donation 5 Other (Specify) Joseph N 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LONKling 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as or rdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumothorax Physician/ hours disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner hous Fall Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the aid 1 Yes 2 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 🗍 No 3 🗌 Probabiy 4 💆 Unknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has! performed? Yes 2 N 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 XNo 1 Mnpatient 2 ER/Outpatient 3 DOA ပ္ 28b. Time of injury filled in by the funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Tes Deumber 8, 2010 730 AM Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6749 Bessen er Avenue 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Home Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DFC 1 0 2010

ANTHONY

32. Registrar's Signature

MD

4940

Eastern Ave

MD

Baltmon

2/22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Nagle Meenan December 2010 8:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Bel Air 102 Nichols Street, Unit F | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | Feb. 5, 1927 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F New York 092-20-9130 Director 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must have some. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 ☐ No Bel Air Marvland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Completed by Funeral** 102 Nichols Street <u>Unit</u> <u> 21014</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 X Yes If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Claims Manager Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Abbott Meenan Thomasine Marie Nagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann K. Meenan / Wife 102 Nichols St., Unit F, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 12-10-10 4 Donation 5 Other (Specify) Towson, Maryland Service Corp. 21. Sig of Fund | Service Licen 22. Name and Address of Facility
McComas Funeral
1317 Cokesbury Home, P.A. Rd., Abingdon May Rd s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. 23a. Part 1, Enter the disease, or complication Approximate Interval Between Shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to ( as a consequence of): Examiner OP Sequentially list conditions, if any leading to incrediate cause. Enter Underlying Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performes No After this certificate 1 🗌 Yes 1 🗌 Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) of certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 0-D 66912 December 9, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 Atwood Road, Bel Air, MD 21014 Venkata Parsa 31. Date filed (Month, Day, Year) 32. Registrar's Signatur

DHMH 17 Rev 7/2009

Registrar

0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ MARSHALL LISA DECEMBER 10:26 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTEMORE UNIVERSITY OF MARYLAND MEDICAL CENTER 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
MD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral**  $J_{\mathbf{u}}^{(Month, Day,)}$ 1 M 2 XF Director 216-96-6979 Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Pasadena Anne Arundel 1 🗌 Yes 2 😾 No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21122 or items 23a o 7812 Mallow Ct. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. traumatic event, the Medical Examiner Armed Forces? 1 ☐ Yes 2 🖾 No Black, White, etc. Specify: South Pacific δ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Islander 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) permit, Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Letecia Sagrado Charles Gordon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Andrew Marshall / Husband 7812 Mallow Ct. Pasadena, MD 21122 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory

Atlantic Crematory Glen Burnie, MD 12/9/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility . Signature of Funeral Service Licenses Ambrose Funeral Home, Inc. 1328 SUlphur Spring Road Arbutus, MD 21227 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ACUTE MYELDED COMPLECATIONS OF resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to lor as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician for use as the hura Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 5 Other (specify) Pregnant at time of death detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Hospital or Attending Physician: The law requires Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) s after death, I Director: After this d in by the funeral d 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined within 24 hours a

To the Funeral D

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 1386969327 MD DECEMBER 3, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

DAUED

DEC

WACKER

STREET

SOUTH GREENE

MARYLAND 21201

BALTEMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar	-	artment e ertificate			lental Hy	giene Reg. No.	20	10	38929	
	Physicia		1. Decedent's Name (First, Middle, Las Shirley Ann Man	7					2. Date of De Month	eath Day		Year	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, To	wn, or Locati	on of Death	12		County		10 P	
~~			FRANKLIN SQUA			osed				Baltimore				
	Funeral Director		5. Social Security Number 6. Sec. 280 – 38 – 3237 1  Usual Residence of Decedent	7. Age (In yrs. I			Year If Un Days Hou	der 24 Hrs. rs Min.	8. Date of Bir 2 – 1 – 1	943		9. Birthp Ohio	place (State or Foreign try)	
	and show lat	or	10a. State 10b. County	10c. Cit	y, Town or L	ocation						1	0d. Inside City Limits	
	Maryli 28a-f	Funeral Director	MD Baltin	nore Co. Ro	seda	le							1 ☐ Yes 2 🕅 No	
-	h the	al Di	10e. Street and Number			10f. Zip Co				-	izen of W	hat Coun	try?	
J	ms 23 must	ner	6501 Hazelwood		n I40		1237				USA			
5 hiri 5-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extminer must be notified at once.	by	11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	5. 13.	Was Decedent If Yes, specify 1 ☐ Yes 2 🖁			city Yes or No- Rican, etc.)			, White, e		
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∫. Yar	Menta arked atic e	မ	Paul Franklin 1	Hendricks			Ma	ary K	athry	n Ca	rr			
Maryland	shour and 7 is m		19a. Informant's Name/Relationship (T)		1	ing Address (Si								
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nor.	age 1 ent of nt: If ii		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	emetery, cre	matory or othe	r place)	12-	11 - 10			•		
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₃ ,[	Physician/		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.				as cardiae c	i respiratory ar	1001,			Approximate Interval Between Onset and Death	
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Division of Vital Records, P.O. Box 68	al or Att s after de l Directe d in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory, of	ffice		28f. Location (S City or Tov		d Number	or Rural	Route Number,	
u	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 ☐ Medical Exami	ician: To the best of my know ner: On the basis of examination e Practioner: To the best of m	n and/or inve	stigation, in my	opinion, deat	h occurred at	the time, date a	and place.	and due t	o the cau	se(s) and manner stated.	
	To t To t		29b. Signature and title of certifier  NAVEEN . V	PORE MD			cense numb				e signed	Month, D		
4	<b>7</b>		30. Name and address of person who c	ompleted cause of death (Item		Print)								
7			DR Naucen Voc 31. Date filed (Month, Day, Year)	9000 P			quar <	- DR	Balto	) M	d	212	37	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JOAN M. NORTON 5, December 2010 4:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Sex 1 ☐ M 2 ☐ X Hours APRIL Day Year) 1932 Director MD 212-28-8110 78 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City. Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MDN/A BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21206 6100 EVERALL AVE APT 407 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 X Married filed within 72 hours after Maryland 21215-0036 WHITE 1 Yes 2 No Specify Specify: "natural" 3 Widowed 4 Divorced Completed Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve once. မ HERBERT REICHARD AUDREY RUTH VIRGINIA MILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $6100\ EVERALL\ AVE\ APT\ 407\ BALTIMORE,\ MD\ 21206$ WILLIAM NORTON-HUSBAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State GARRISON FOREST 12/15/10 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BALTIMORE, MD 21206 6415 BELAIR RD 23a, Part 1, Enter the disease implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure dist only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed SENING that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? à COLITIC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5  $\square$  Pending 1 Yes 2 No 2 Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination arrayon investigation, array operations and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Amend Item 23a per dr., g912,02/14/2011dhb Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 23e per dr., g910, 12/29/2010dhb

Certificate of Death

Reg. No. 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 17:55 M Mary Helen Nippard 04 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Ac. County of Death **Examiner** Agnes hospita Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8/22/1938 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Days Hours Min. 72 Director 217-38-9601 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinating any Injury or other traumatic event, If a Medical Examinating and Injury or other traumatic event, If a Medical Examinating and Injury or other traumatic event, If a Medical Examinating and Injury or other traumatic event, If a Medical Examination Injury or other traumatic events. Director 1 □Yes 2□No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2018 Drummond Rd 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2**XX**No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: White 1 ☐Yes 2 ◯ No Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Meade Helen Katherine Ruhland Hesson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roos Nippard/ Husband 2018 Drummond Rd, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory Dec. 6, 2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Rome Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon Cancer **Physician** 1 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Colon Cancer Hears. Sequentially list conditions, if any, leading to immediate cause Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-trar law requires that the death certificate be execu Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ⋧ 1 ☐ Yes 2 No 3 ☐ 1 obably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 **12**No Vital 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of Medical Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 ☐ Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after deat Puneral Director; 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ishor 12/04/2010. P25924. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shrestha Baltimore, MD 21229. goos. caton Ave, handra 32. Registrar's Sinature State Registrar DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) DeMamber 5° 2010° 1:05 а м Physician/ Salvina C. Nunez Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore 2710 Wilkens Ave Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Hours Min. Fellonth, Pay, Yea 1920 Previones 1 M 2 F 90 215-08-2023 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at **Funeral Director** 1 Yes 2 No MD N/ABaltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ò 23a USA 21223 2710 Wilkens Ave "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. Yes 2 A No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Asian If Yes. Give 3 Widowed 4 □ Divorced Year or Dates and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 27 is marked or traumatic eve Bondoc ပ္ Juliana Castaneda Ρ. Regino 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 126 N. Beechwood Ave., Catonsville, MD 21228 Lourdes N. Estrada (Daughter) f Health item 27 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Inportant: If ite Baltimere Crematory

@ Loudon Park 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State injury or 12/9/10 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudon Park Funeral Home Baltimore. MD 21229 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. set and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Pancresso & Liver Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has hear a completed filled in by the first. Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No M Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. muress m 3721 Potest Balto. mdz1225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUNETE State

Registrar

10-09315 Joseph Anthony Pecora

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | D State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar			Ce	ertificat	e of	Deat	th			R	eg. No	).		
Physicia	ın/	Decedent's Name (	First, Middle,L	ast)							2	. Date of Dea	ith			3. Time of Death
edical Exami	ner	Joseph A	nthony	Pecora								Month Decembe	Day r 4, 2	Yea 2010	r	1028 hrs
		4a. Facility Name (if n			umber)		41	c. City,	Town, or Lo	ocation of				c. County o	f Death	
		Upper Chesa	peake Med	ical Center				Bel A	\ir					Harford		
Funeral		5. Social Security Nun	mber 6.	Sex	7. Age (In yrs.	last birthd	ay)	If Und	ler 1 Year	If Under	24Hrs.	8, Date of Bi	rth(MN	I/DD/YYYY		hplace (State or
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21215-0036 hould be filed within 7 id Mental Hygiene. is marked other than tic event, the Medica	2	19a. Informant's Name		(Type, Print )		19b. I	Mailing A	Address				ral Route Nur			n. State.	Zip Code)
_ 0 75 ea 15	-1	Trish Wal	ters (	Daughter	.)							Bald				
and and tent	ŀ	20a. Method of Dispos	•	. 0	•	. Place of I	Dispositi	ion (Na	me of ceme			Date		·		Town, State
Baltimore, MD eemit. Pages I and 2 sh Department of Health an important: If item 27 is		1 Burial 2 X	Cremation	3 Removal f		cremator					10 0	0.0010		1		N.C.
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Box 68 e death certil the attending ed for use as	Physician	1 Yes 2 No	g Unkno			2 [	Othe	er (Spe	ciry)				1			
C : the d	듄	Part II. Other signific	ant condition	s contributing	to death but not	resulting is	n the un	derlying	g cause giv	en in Pari	t I.	23e. Did t	obacco	use contrib	oute to t	he cause of death?
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Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the control of the funeral director, page 2 should the funeral director.	팃												2 🗸 !		Ye	s 2 No
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Division of Vital Records, P.O. Box 68760,  Rospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and tell filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification: To	4 Homicide	determi	ned (Specify	Home						4	10 East McF	hil R	oad, Bel A	ir, MD	
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Divis  To the Bospital or At within 24 hours after d To the Funeral Direc	Medical	one) 2 M	edicai Exami	ner: On the basis and manner		and/or inv	estigatio	on, in m	y opinion, o	death occ	urred at t	the time, date	and pl	lace, and du	ie to the	cause(s)
	ž	29b. Signature and tit	le of certifier					29	c. License	number			29d.	Date signe	d (Mon	th, Day, Year)
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		30. Name and addres	s of person wh	no completed cau	use of death (Ite	m 23a)								-		
		Ana Rubio MI	D. Assis	tant Medical	Examiner	111 Pe	enn St	reet, l	Baltimore	e, MD 2	21201					
St	ate	31. Date filed (Month,	Rayman	32. F	egistrar Signa	Jack	2									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38934 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 5:20 P 2010 Paul Pohuski December Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month Day, Year)

Dec. 15, 1927 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Hours Pennsylvania 1 🕱 M 2 🗆 F 82 Director 165-22-5645 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State Director 1 ☐ Yes 2 1 No Catonsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21228 Funeral 123 Bloomsbury Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married δ White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15 Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Photography Owner/Operator 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Zaharis ည Onufry Pohuski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 123 Bloomsbury Avenue; Catonsville, MD 21228 Wife Mary Pohuski 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem.Park 12/11/2010 Elkridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Funeral Service Licensee M01050 1630 Edmondson Avenue: Catonsville MD 21228 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death End-Stage Immediate Cause (Final Cardiomyopathy Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Unidentifying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Yes 2 No signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Dunknown 1 Yes 2 No plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed Yes 2 1 Yes this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 2 🖸 No 6 Other (Specify) Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred funeral To the Funeral Director: After completed filled in by the funer 5 Pending 1 Matural 1 Ves 2 No death. Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide within 24 hours To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.S. Rayapa Kemio. 31. Date filed (Month, Day, Year) 32. Registraris Signature

29b. Signature and title of certifier

N S RY UP WHEN D

29c, License number

D0657465

29d. Date signed (Month, Day, Year)

12/8/10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 38935 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 6. 2010 December 3:25 P. M Frank I. Parsons, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Marriottsville Marion Hall If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Feb. I7, Year 1917 1 **X** M 2 □ F Months Days Hours Min Mary Land Director 213-10-7882 Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Director ortant: If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 🔀 No York Stewartstown PA 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral 17363 USA 3733 Cutler Court permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner must one. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black White etc 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give White Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Food Salesman 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Florence Rebecca Apsley Frank I. Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4057 Jay Em Circle; Ellicott City, MD 21042 Michael Blair Parsons Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ce. View Mem. Park 1 M Burial 2 Cremation 3 Removal from State 12/11/2010 Eldersburg, MD Lake 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Lice Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ goor disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ending physician and use as the bunal-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: hours after death. uneral Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier e and address of person who completed cause of death (Item 23a) (Type, Print) HARLIKES M N

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 6, Richard Anthony Pizza 2010 11:43 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Days Hours NOV 2 **1930** Director Marvland 212-28-8971 80 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 819 Peppard Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by 1 Yes 2X No Specify: Specify: "natural" 3 Widowed 4 Divorced White Year or Dates Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) injury or other traumatic event, the q Owner/Operator Industrial Tike Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland bet ပ Anthony Francis Pizza Marie DiNetta Genovese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.0</u> 819 Peppard Drive, Bel Air, MD 21014 Theresa M. Pizza / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 12-7-10 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Si vature/pf/Funeral/Gervice ²² Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 잍 1 Yes 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director; After th Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Precitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 0036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m·D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frank Pellegrini Anthony Decembei 20105:45 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Somerford Place Columbia Howard Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 X M 2 □ F Months Days Hours Min July 17, 1930 Director 215-28-2697 80 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 2 Corner Court Unit 101 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? . O. Black, White, etc. Completed by 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify "natural", 3 X Widowed 4 Divorced White Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Industrial Engineer Steel Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be Joseph (nmn) Pellegrini Rose (nmn) Garbo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 10205 New Forest Court, Ellicott City, Maryland Michael Pellegrini / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn. 12/10/2010 Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death 1 Yes 2 No 4 ☐ Pregnant : 9 ☐ Unknown been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Essential Hypertension 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe page 2 2√∏ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital Other: 4 \( \subseteq \text{Nursing Home } 5 \subseteq \text{Residence } 6 \text{XXOther (Specify) } \text{Assisted} X□ No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Living injury 1 X Natural 5 Pending within 24 hours after death
To the Funeral Director: A
completed filled in by the fi 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 56531 December 8, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+1 8600 Snowden River Parkway, #301, Columbia, MD 21045 Harry Li 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parks 2010 Registrar DEC

HDHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:20 PM EARL 2010 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTI MORE JOHNS HOPKING BAYVIEW MEDICALCENTER If Under 1 Year Jf Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8 Date of Birth Funeral (Month, Day, Year) OV 27 1920 West Virginia Days Min. 1 □ M 2 🔽 F 233-28-7775 Nov Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County Director 1√ Yes 2 □ No <u>Baltimore</u> MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21222 Jaydee Avenue Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify. white 3 😾 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) medical billing officer supervisor 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Blanche Elva Round Charles Ray Dean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 887 Jaydee AVenue Baltimore, MD 21222 19a. Informant's Name/Relationship (Type, Print) Pearl Norman/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 
Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Romal Service State Anatomy Board 655 W. Baltimore Street Baltimore. MD Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Hupotension Physician/ Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil Cause (Disease or iiniun that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) rate has been signed by the a page 2 should be detached f 1 ☐ Yes 2 L 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical 29a, Certifier 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar em Ave Battimore MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Reeve MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certifica	ate of Death	Reg. No	).	0000
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death     Month Day	Year	3. Time of Death
ecical Exami	ner		Ab Oite Town and agelian of Double	November 21,	2010 lc. County of Death	2107 hrs
1		Facility Name (if not institution, give street and number)     114 Fairground Avenue	4b. City, Town, or Location of Death Hagerstown		Washington	
Funeral		5. Social Security Number 1171 6. Sex 7. Age (In yrs. last birth			•	pplace (State or Foreign
Director		1 M 2 F 68	Yrs. Months Days Hours Min.	Dec 12,	Cou	ntry) UIIK
	H	Usual Residence of Decedent	110.	Dec 12,	1941	
any	- 1	10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ᅵ	MD Washington Hag	erstown			1 Yes 2 No
Maryla 28a-f d at o	Director	10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Coun	try?
h the l 3a or		214 Fairground AVenue	21740		USA	
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	uneral	11. Marital Status UNK 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? unk	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F</li> </ol>		<ol> <li>Race - Americ</li> <li>White, etc.</li> </ol>	an Indian, Black,
er dea	╙	1   Never Married   2   Married   1   Yes   2   No     3   Widowed   4   Divorced   If Yes, Give Year	1 Yes 2 X No specify:		Specify: Whit	e
urs aft tural" tmine	ğ	15 Decodort's Education (Specify only highest grade completed) 16a F	Decedent's Usual Occupation (Give kind of we	ork done 110 16b.	Kind of Business/In	
72 hou n "nat	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life, DO NOT use retire	ed) dirk		dik
036 ithin ne. r than	ם	unk unk				
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	ပ	17. Father's Name (First, Middle, Last)	unk 18.Mother's Name	(First, Middle, Maider	n Surname)	unk
D 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "natural", natic event, the Medical Examiner.	o Be	19a. Informant's Name/Relationship (Type, Print ) 19b	. Mailing Address (Street and Number or R	ural Poute Number (	City or Town State	Zin Code)
hou hou is n atic	ř	O.C.M.E.	111 Penn Street Balt		21201	2.5 0040)
ore, ME ss 1 and 2 s of Health au If item 27 her traums		20a. Method of Disposition 20b. Place of	f Disposition (Name of cemetery,		Location - City or 1	own, State
ages 1 nt of B		T Burial 2 Cremation 3 Removal noin state	ory or other place)			
	- 4	4 Donation 5 X Other Specify: in state  21. Sign. of Funeral S.rv. icensee  8 e v ector	22. Name and Address of Facility State Anatomy Board			Ctmoot
Balt permit. Departi Import injury	111	14680111111111	IPoltimore MD 2120	11		Street
Physician		23a. Pan I. Enter the disease of complications that caused the death. Do not failule. List only one cause on each line.	t enter the mode of dying, such as cardiac or	respiratory arrest, sh	nock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Carse (Final disease a Atherosclerotic Cardiovascul	ar Disease			Death
, ê		or condition resulting in death)  Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):				
	Examine	c. (Disease or injury that initiated events resulting in (each). Last Due to (or as a consequence of):				-
ted 1 Insit		events resulting in death) Last Due to (or as a consequence or):  d.				
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60, ate be	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23	3d. Date of delivery	
687 certific ding p	ian/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5		ncy	Month Da	ay Year
Sox 68' leath certifi e attending for use as i	Physician	1 Yes 2 No 9 Unknown Pregnant at time or death 5	Other (Specify)			
D. B. t the de by the		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
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tal Recionant The laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the laction to the lac	o l	25. Was case referred to medical	26.Place of Death (Check o	only one)		
Vita	.o	examiner?  1 Ves 2 No Hospital: 1 Inpatient 2 ER/Ou		Home 5 Resid		Scene
n of \ding Phy.	<u>-</u>	(Month, Day, Year)		28d. Describe how in	njury occurred	
sion ttendideath.	atio	2 Accident Investigation	1 Yes 2 No			
JVIS d or A after Direction by	Certification:	Suicide Could not be determined (Specify)	rm, street, factory, office building, etc.	28f. Location (Street or Town, State)	and Number or Run	al Route Number, City
ospita hours unera		4   Homicide (Specify)  29a. Certifier (Check only 1   Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place, and	due to the cause(s) a	and manner as state	4
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transitions.	Medical	one) 2 Medical Examiner: On the basis of examination and/or in				
To To con	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number	29d	. Date signed (Mon	th, Day, Year)
		With I then hele the	O.C.M.E.	No	vember 22, 20	10
_		30. Name and address of person who completed cause of death (Item 23a)				
		Victor Weedn MD JD Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2	21201		
S Regis	tate		4			
		plane p.	garles			
DHMH 17 Rev 1/2	UUI	OCME OR	GINAL			

DHMH 17 Rev 1/2001 OCME 2006

OCME

10-09242 David Noel Ruth

		1- For State Registrar	Certifica	ate of De	eath		Reg	g. No.	1 0	00090
Physicia	ın/	Decedent's Name (First, Middle,Last)					Date of Death     Month		.	ime of Death
edical Exami		David Noel Ruth					Month December		'	1729 hrs
		4a. Facility Name (if not institution, give street and number)			ity, Town, or Lo Iver Spring	ocation of Death	1	4c. County o Montgon		
		1502 Timberline Road	(In yrs. last birth		Under 1 Year	If Under 24Hrs	8 Date of Birth			ce (State or
Funeral Director	Н		, ,	Me	onths Days	Hours Min		(MM/B337***)		
Director	ļ	190-22-8607 1XM 2□F	79	Yrs.			Jan 10	, 1031	Perms	ylvania
any .	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location					10d	I. Inside City Limits
		,			in-				1 [	Yes 2 No
Maryland 28a-f show d at ooce.	흱	MD Montgomery 10e. Street and Number	211	ver Sp	Zip Code		10	g. Citizen of Wh		
th the Maryland 23a or 28a-f sho ootified at ooce.	Director	1502 Timberline Road			•	20904		US	SA	
death with the Maryland or items 23a or 28a-f sh must be ootified at ooce			er in U.S.	13. Was Dec			pecify Yes or No-			Indian, Black,
eath w	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2	X No			Mexican, Puerto		White	, etc.	
fter d		3 Widowed 4 Divorced If yes, Give Year	NO	1 Yes	2X No	specify:		Specify:	whit	e
ours a	d b	15. Decedent's Education (Specify only highest grade com				n (Give kind of OO NOT use ret		16b. Kind of Bus	siness/Indus	stry
5-0036 ted within 72 hor tygiene. other thas "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5	+)		3		ired)	. 1	. + - 1 2	
Medical	Ē	12 5+		colle	ge tead			educa		
	Ö	17. Father's Name (First, Middle, Last)			18		e (First, Middle, M ginia Sm			
2121: uld be fi Mental I marked	O B	Ira M. Ruth  19a. Informant's Name/Relationship (Type, Print)	19b	. Mailing Add	ress (Street a		Rural Route Numi		n, State, Zip	Code)
Baltimore, MD 21 permit. Pages I and 2 should I Department of Health and Mer Important: If item 27 is man injury or other fraumatic ev	5	O.C.M.E.					timore,M			
and and tealth		20a. Method of Disposition			(Name of ceme	etery,	Date	20c. Location -	City or Town	n, State
Baltimore, bermit. Pages I an Department of He important: If ite		1 Burial 2 Cremation 3 Removal from Sta	te cremato	ory or other pl	ace)					
Baltimo permit. Page Department o Important: injury or ott	H	4 X Donation 5 Other Specify: 21. Signature 1 Funeral Service Licenses		22. Name	and Address o	f Facility		20		-
Dep Dep	J	Something S. Made, Wir	ctor	State	e Anato Lmore, l	my Boar MD 212	d 655 W.	Baltim	ore S	treet
Physician	10	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.		t enter the mo	ode of dying, su	uch es cardiac		st, shock, or hea	nrt Ap	oproximate Interval etween Onset and
Examiner		Immediate Cause (Final disease a. Atheroscle	erotic c	ardiov	ascula	r disea	se		- 1	Death
LAGIIIIICI	-1	or condition resulting in death)  Due to (or as a conse	quence of):							
	<u>.</u>	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a conse	quence of):						-	
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated								
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760, cate be ex physician he burial	Medical	- 23a,2/,	oer ME g	g910 12	2/22/10	TT		23d. Date of	deliven	
8760, ifficate by ng physic	an/M	IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth	e or pregnancy 2	Fetal de	eath 3	Ectopic pregn	ancy	Month	Day	Year
eath certific eath certific e attending of or use as the	icia	past 12 months?			Specify)			1		
Box is death or the attented for us	Physicia	1 Yes 2 No 9 Unknown 9 Unknown	17			i- B-41	22a Did to	pacco use contril	huta ta tha s	auco of death?
P.O.	by F	Part II. Other significant conditions contributing to death	but not resulting	j in the under	iying cause giv	en in Part I.			_	4 V Unknown
S, P.C juires that an signed ald be deta							24a. Was a			y findings available
cord	믕						autops	sy p		letion of cause of
Rec The la	Completed							No 1	Yes	2 No
iao: The certificate ector, page	Be	25. Was case referred to medical examiner?   Hospital:				of Death (Check			7	
of Vital Records, g Physiciae: The law requir the this certificate has been s neral director, page 2 should t	٥	1 ✓ Yes 2 No		utpatient 3			ng Home 5 F	Residence 6 v		ene
After funer		27. Manner of Death  1 X Natural  5 Pending  28a. Date of Injuit (Month, Day, Ye		Time of Injury	1	at work?	26d. Describe n	ow injury occurre	<del>s</del> u	
SiO Affen death of the	cati	Natural 5 Pending 2 Accident Investigation 28e. Place of Inj	unu At homo fa	rm street fac			28f Location (S	treet and Numbe	er or Rural R	loute Number, City
Division tal or Attentia is Barcetor A	Certification:	Suicide Could not be determined	ury - At Home, la	iiii, street, iat	ctory, office but	ildirig, etc.	or Town, St		, or reading	iodic ridinbor, only
file ou		29a. Certifier 1 Continues Physician: To the best of my	knowledge des	ath occurred a	t the time date	and place, and	d due to the cause	e(s) and manner	as stated.	
To the How within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of exam	nination and/or in	nvestigation, i	n my opinion, o	death occurred	at the time, date a	and place, and du	ue to the cau	use(s)
To Sor	Me	29b. Signature and title of certifier		2	29c. License	number		29d. Date signe	ed (Month, L	Day, Year)
		111/1	21	7)	O.C.M	.E.		December	2, 2010	
		30. Name and address of person who completed cause of do	eath (Item 23a)							
		Russell Alexander MD. Assistant Medica	al Examiner	111 Per	nn Street, E	Baltimore, N	ID 21201			
	ate	31. Date filed (Month, Day, Year) 2010 32. Registrar	's Signature	bare						
Regis	964	Colo	The same	XXIII WWW						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Maryland / Department of Health and Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydiene and the state of Mental Hydie

		•	For State Registrar	State of Ma	ıryıarı		tificate of t			entai Hy	gien Reg. N	2 U	10	3 8	3941
	Physicia		1. Decedent's Name (First, Middle, Las Charles Henry Rid	,						2. Date of De Month	D	0 0 10	Year		e of Death
	Medio Examir عر		4a. Facility Name (if not institution, give Stella Maris Hosp				4b. City, Town, o	r Location		<i>Dec.</i> /	4	c. County	of Death		
Ī	Funeral Director		Social Security Number 6. S			ast birthday) 6 Yrs.	If Under 1 Year Months Days	If Unde Hours	er 24 Hrs. 8 Min.	B. Date of Bir (Month Da April	th			place (Sta	ite o <i>r Foreign</i>
	ind show at	ē	Usual Residence of Decedent  10a. State 10b. County			y, Town or Loc	ation					.,,,,,			e City Limits
	Maryla 28a-f s notified	irect	Maryland Harford	County	Bel	Air								1 🗆	Yes 2 🕅 No
	n with the ns 23a or nust be r	Funeral Director	10e. Street and Number 400 East Harrison	Court Apt	. 5		10f. Zip Code 21014						What Coun State:		
5:45 a.m. 215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Narried 3 Widowed 4 Divorced	Tour or Buttoe.		If	/as Decedent of H Yes, specify Cuba ☐ Yes 2【】No			fy Yes or No- can, etc.)		Blac	e - America k, White, e <b>Whit</b> e	etc.	3
5:45 215-00	n 72 ho e. ian "na' Medic	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)	ducation ade completed) College (1-4 or 5+	)	(Give k	ent's Usual Occup ind of work done ( ) NOT use retired)	ation during mo	st of working				usiness inc	,	•
	ed withi Hygiene other th	Be Co	12. Father's Name (First, Middle, Last)	N/A	,	Layou	t operat		havia Nama C						
20 ylan	should be filed v h and Mental Hyg 7 is marked othe traumatic event,	2	Joseph S. Rider							First, Middle, ricker		n Surname	, 		
DECEMBER 7, 2010 Baltimore, Maryland 21	2 ± 23 ± 24		19a. Informant's Name/Relationship (7) Anna Rider (Wife)	/pe, Print)		19b. Mailing 400 E	g Address (Street ) ast Harr	and Numb ison	er or Rural F Court	Route Numbe	r, City o	r Town, S Bel	tate, Zip C Air,	ode) MD	21014
DECEMBER altimore, N	age 1 and ant of Heal it: If item 3 y or other		20a. Method of Disposition 1 ☐ Burial 2	Removal from State	C	emetery, crem	ition (Name of atory or other place		Dat	- 1			City or To		
DEC Saltir	permit. Pa Departme Importan any injury		21. Signature of Funeral Service Licens		Eva		eral Cha				_		_		ryland BelAir
	<u> </u>	0 1	23a. Part 1. Enter the disease, or comp	olications that caused t	he death		Name and Address Ans Fune Newport the mode of dyin					Mary	<u>land</u>	210 Approxir	
	Physician/ , Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. PROSTAT										Interval I Onset ar	Between
	Examiner	_		Due to (or as a o	consequ	ence of):									
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to for as a c	ountequ	ense of):									
_	cate be execut <b>ed</b> physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a c	consequ	ence of):							7		
68760	tificate b ng physi as the k	Medic	IF FEMALE:	d							_				
. Box	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at t 9  Unknown	☐ Fetal	Ideath 3 🗌	Ectopic pregnand Other (specify)	ey .				23d. Date Mor	e of delive	ry Day	Year
RIDER ds, P.O	es that the signed by the	þ	Part II. Other significant conditions co	entributing to death but	not resu	ulting in the un	derlying cause giv	en in Part	: L.	23e. Did to		j	_		of death?
	w requires is been sig	Completed								24a. Was a	an	24b. W	Vere autop	sy finding	gs available
CHARLES ital Reco	n: The la ficate ha r, page		25, Was case referred to medical							1 🗆 Yes	rmed?	d	eath?		of cause of
	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 🗶 No	Hospital:	t_2 🗆 I	ER/Outpatient	Othe	)k.	ath (Check or lursing Home	nly one) 5 ☐ Resid	lence (	6 <b>X</b> Other	(Specify)	HOS	PICE
on of	nding Pl tth. : After the e funeral		27. Manner of Death  1       Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Y	Year)	28b. Time of injury	28c. Injury work M 1	at	280	l. Describe h					
Division	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		- At hor Specify)	ne, farm, stree	et, factory, office		281	f. Location (S City or Tow			or Rural F	Route Nui	mber,
	e Hospi 24 hou e Funer bleted fill	Medical	(Check 2   ☐ Medical Exami:	ician: To the best of my ner: On the basis of exame Practioner: To the be	mination	and/or investig	ation, in my opinio	n. death o	occurred at the	time data a	nd place	and due	to the caus	eale) and r	manner stated.
	To th Within		29b. Signature and tiple of certifier	DINA			29c. License		07				(Month, Da		
			30. Name and agdress of person who c	ompleted cause of dear	th (Item	23a) (Type, Pri	nt)	71	10			41	100	10	
10+	Stat	e	JACKIE JONES, C	RNP 2300 I 32. Registrar's			LLEY RD.	TIM	ONIUM	MD 2	109	3			
1/	Registra	_	LIEU 1 0 2010 /2-1	was II. a	Saul	Les .									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗋 38942 1 - State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER RUTH V. SCHMIDT 2010 2:27 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS TIMONIUM BALTIMORE if Under 1 Year If Under 24 Hrs. 1922 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth . Social Security Number **Funeral** NOV 23, 2010 Days Min. Months Hours 1 □ M 2 😾 F 88 217-16-3517 Yrs MD Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director must be notified 1√2 Yes 2 ☐ No MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö , or items 23a Funeral 4404 GLENARM AVE 21206 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural" 3 X Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) marked other than College (1-4 or 5+) and Mental Hygiene. CLERICAL INSURANCE Be 2010 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) LILLIAN EILERMAN DANIEL RILEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 27 is permit. Page 1 and 2 sl Department of Health a Important: If item 27 is EVELYN MCKENNY-NIECE 5210 SWEET AIR RD BALDWIN, MD 21013 DECEMBER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other pi 1 XBurial 2 Cremation 3 Removal from State 12/11/10 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service License 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1. Enter the disease of complications that caused shock, or heart failure ast only one cause on each line emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) METASTATIC CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

The properties of time of death 5 Other (specify) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 X No Month Day Year ed by the a 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: Other: 1 Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 No Other (Specify) HOSPICE this 28a. Date of injury (Month, Day, Year) Director: After the 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined hours after within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurses a ractioner. To the basis of my increasing a state of the cause of my increasing a state of the cause of my increasing a state of the cause of my increasing a state of the cause of my increasing a state of the cause of my increasing a state of the cause of my increasing a state of the cause o 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 201 of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JACKIE

JONES,

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Sine ture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 38943 State of Maryland / Department of Health and Mental Hygiene 4 U | U State Registra Certificate of Death 1. Decedent(s Name, (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9307 M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death N/A Seasons Hospice Baltimore 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. 02/11/1940 Yrs **Director** 70 Maryland Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and the model. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore 10e, Street and Number 10g. Citizen of What Country? Funeral 2313 Monticello Rd. 21216 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Divorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tax Assessor State of Maryland years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John R. Sparks Irene O. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Smith(wife) 2313 Monticello Rd., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation 5 Other (Specify) 12/06/10 Baltimore, MD 21. Signature of Funeral Service Licens sephadades of Brown Jr. Funeral Home 40 N. Fulton Ave., Baltimore, MD PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final «Pnysician» disease or condition resulting in death) neumme Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Uisease or imjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and abe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day 1 Li Yes 2 Li 9 Dinknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 performed? Yes 2 No After this certificate funeral director, pag 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? HOSPICE Hospital Other: မြ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) within 24 hours a
To the Funeral C Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

6

MANTIN PAUL STUNGEON Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 10-09363 Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day December 6, 2010 **Medical Examiner** 0712 hrs Martin Paul Sturgeon, Jr 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 250 S. Eaton Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Unk 1 M 2 F 27 Country) 11/10/1983 MD Usual Residence of Decedent 10a, State 10c, City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No or 28a-f show Dundalk MD Baltimore "natural", or items 23a or 28a-f sho Examiner must be notified at once, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 喜 18 Kinship Rd. 21222 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 1 Yes 2 No specify: Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. In Jiem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Com Laborer Construction 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Sturgeon, Sr. <u>Kaysha Sites</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Sturgeon, SrFAther 18 Kinship Rd
20b. Place of Disposition (Name of cemetery, Dundalk. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 9, Dec. Beltsville, MD Chesapeake Donation 5 Other Specify Crem. 2010 22. Name and Address of Facility CAFA/Stephen D.Lohrmann 21. Signature of Funeral Service Licensee MO1585 Green Pastures Dr Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea **Physician** failure. List only one cause on each line. Between Onset and /Medical Narcotic (morphine) intoxication Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause: Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED attending physician or use as the burial -AMENDED 23a,27,28a-f,pe rME g910 12/22/10 TT IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Records, P.O. Box 68760,

this certificate has been d in by the f

á

Completed

Be

Certification

Medical

one)

25. Was case referred to medical

1 🗸 Yes

27. Manner of Death

Natural

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Donna M. Vincenti, MD

2 Accident

2 No

5 Pending

6 X Could not be

Investigation

Hospital or Attending Physician: Division of Vital 24 hours after death.

31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

OCME 2006

32. Registrar's Signature

Assistant Medical Examiner

28a. Date of Injury (Month, Day, Year)

(Specify)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Fd 12/16/10 Fd 7:00 am

found in house

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Yes 2 No 3 Probably 4 Unknown

death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)  $250\,S\cdot\,Eaton\,St$  Baltimore, MD

December 6, 2010

29d. Date signed (Month, Day, Year)

1 🗸 Yes

24b. Were autopsy findings available

prior to completion of cause of

24a. Was an

26.Place of Death (Check only one)

28c. Injury at Work?

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

1 Yes 2X No

autopsy

performed?

✓ Yes 2 No

Other Nursing Home 5 Residence 6 Other: Scene

28d. Describe how injury occurred

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38945 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 8, 2010 Frank John Smith 7:04 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F (Month, Day You Year. 1923 Pennsylvania **Director** Yrs 193-14-0175 Usual Residence of Decedent shov 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 X No Maryland Harford Forest Hill 10e. Street and Number ō 10f. Zip Code the Medical Examiner must be 10g. Citizen of What Country? 23aFuneral 1706 Landmark Dr., Apt. H 21050 USA items ; 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? ō 1 Never Married 2 Married Black, White, etc. Ş If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 - Widowed 4 - Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Manager Water Company 27 is marked other traumatic event, Be Baltimore, Maryland and 2 should be filed Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank John Smith Sr. Cecelia Marie McGuire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 Department of Health Important: If item 2: any injury or other to Elaine M. Smith / Wife 1706 Landmark Dr., Apt. H, Forest Hill, MD 21050 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cemetery 12-11-10 Bel Air, Maryland f Funeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, athler 317 Cokesbury Rd., Abingdon. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lim. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 0 disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): executed attending physician and for use as the burial-transit Cause (Disease or linjury resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year ate has been signed by the a page 2 should be detached f Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?, b 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 1 Yes 2 No ☐ Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify 27. Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 4 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) Ra 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 rev 1101

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

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32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 20 TO 8:38 A M Ρ. Ann Suskind Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1724 Grandview Road Pasadena 5. Social Security Number 9. Birthplace (State or Foreign Country) Illinois If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 🗆 M 2 🔀 F Dec. 14, Hours Year 1928 Director 81 Yrs. 092-22-4704 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Kent Worton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21678 USA 24188 Mac's Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Dowling Parker Isadore Edward Lowenberg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark J Suskind-son 3018 Rockdale Road, Freeland, MD 21053 20a, Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State Date 🔲 Burial 2 💢 Cremation 3 🗌 Removal from State Glen Burnie Maryland Dec.8,2010 4 Dopation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road, Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Smonth Immediate Cause (Final Ph_sician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of, Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-transi and Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? Director: After this certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: friend's 1 ☐ Yes 2 ☑ No 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Medical LX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cnly one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0051170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 1650 Orleans Street, Balt more, Maryland

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

facels

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0: 00 P M P aina ro 200m bor Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death · (-liza beth Nursin Saltimore ent 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Min. Aug 31 Day, Y 215-14-4021 88 Maryland **Director** Usual Residence of Decedent 28a-f show 10a. State with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No Md. Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3206 Hudson Street 21224 U.S.A. hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ð 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4 Vrs Elementary/Seconday (0-12) 12th Registered Nurse Mercy Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Sroka Cecelia Rosinska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Hoban Court Notting 19a. Informant's Name/Relationship (Type, Print) Hoban Court Nottingham, Md. 21236 Deborah Fodel (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December cemetery, crematory or other place)
St.Stanislaus Cem 1 Durial 2 Cremation 3 Removal from State 11,2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caczorowski Funeral Home, FA 21. Signature of Funeral Service Lice 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). physician and the burial-transit ensin or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending ploched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year cate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has performed? death? funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. I Director: After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined within 24 hours at To the Funeral D Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2122 2 0 enson 31. Date filed Month, Day, Year) 32. Regist ar's Signature State Registrar

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 2010 5: 20 PM DECEMBEIZ Marian Trifon /Medical Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPITAL BALTIMORE HGNES 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) unk **Funeral** Months Days Hours 1 □ M 2 🛱 F Nov 21, Director 220-40-4904 68 1942 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 ☐Yes 2 ☐ No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ь 701 Edmondson Avenue 21228 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: items 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: white ≥ 3 Widowed 4 Divorced Completed DESIG unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other transcent. 12 unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 Caton Avenue Baltimore, MD 21229 St. Agnes Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5點Other (Specify) in state 21. Signa is of Funeral Service Licensee Ronald S Waste State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part a Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C (Final disease or condition resulting in death) CEREBROVASCULAR ACCIDENT **Physician** /Medical Due to (or as a consequence of): Examiner - IBRILLATION ATRIAL UNKNOWN squeritially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-tra Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Į Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed HYPER LIPIDE MIA 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an has page 2 s CAROTIIS certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **☑** No 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ပ္ 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760 Ö ٦. Records, Division of Vital MARI

Hospital or Attending Physician:

n 24 hours after death.

The Funeral Director: A pletely filled in by the fi

State Registrar

ical Medi 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier (herson up)

DOO 60105 | BECEMISER 1 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KANL SUIST-ITERS OF MD 900 S CATOH AVENUE BARTIMARE MW 21229

and manner stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 12-8-2010 9:10 PM Medical 4a. Facility Name (if not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death Baltimore OWSON 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday) **Funeral** Days Director ortant: If item 27 is mar led other than "natural", or items 23a or 28a-f show injury or other traumati event, the Mec ical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Blac 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation Give kind of work done during DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) tac Be ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is mar er any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 hrockmorten 15 norr, MD 21230 Place of Disposition (Name of cenetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signar re of Funeral Service Licers 8728 Libert 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ PARC METASTATIC Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Month Day Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PANCREATITIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? TYPE 2 DIABETES MELLITUS autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 . No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 28a. Date of injury (Month, Day, Year) Certificate: 27, Manner P Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled i Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			Please In amend #17 P	ype or Print in Blad State of Maryland	ck Ir 6/1 Depa	idelible ink Out artment of H	k. Ensure A lealth and N	<b>III Copies</b> Iental Hyg	s <b>Are Le</b> giene	gible.	
			State Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of E	eath		Reg. No.2 0	10	38950
	Physicia Medic		DORIS DELL WOOD					2. Date of Dea 12/08/2		Year	3. Time of Death 7:20Р м
	Examin	er	4a. Facility Name (if not institution, give street Blakehurst	eet and number)		4b. City, Town, or TOWSO	Location of Death		4c. Count	ty of Death Bal	timore
	Funeral Director		5. Social Security Number 6. Sex 1 —	M 2 <b>XX</b> F 92	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	948	9. Birth	place (State or Foreign
	nd how at	ř	Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Loc	cation					10d. Inside City Limits
	Maryla 28a-f s ootified	irect	Maryland Baltimor	e Towso	n						1 ☐ Yes 💥 💢 No
	with the s 23a or ust be r	Funeral Director	1055 West Joppa Roa	d		10f. Zip Code 21204			10g. Citizen of USA	What Coul	ntry?
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	δ P	11. Marital Status 12  1 ☐ Never Married 2 ☐ Married 3 ★ Widowed 4 ☐ Divorced	. Was Decedent Ever in U.S. Armed Forces V 1 ☐ Yes 2 1 No If Yes, Give Year or Dates.	1	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	cify Yes or No- Rican, etc.)		ace - Americ ack, White, fy: W	
215-0	n 72 hou  an "natu Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give k	ent's Usual Occupa kind of work done d O NOT use retired)	ation uring most of worki	ing	16b. Kind of I	3usiness In	dustry
212	d within lygiene.	டுவ	12	College (1-4 or 5+)	Hon	nemaker				wn Hor	те
/lanc	ould be filed and Mental Hy marked oth amatic event		17.Father's Name (First, Middle, Last) Harold Kleiber <del>Wood</del>				18. Mother's Name	e (First, Middle, 1 Legore	Maiden Surnan	7e)	
Baltimore, Maryland 21215-0036	12 should lith and Me 27 is marl r traumati		19a. Informant's Name/Relationship (Type, Kathryn Kimberly Fa	, , , , ,		g Address (Street a					
ore,	ge 1 and at of Hea is If item or othe		20a. Method of Disposition	20b. Place o cemete	f Dispo	sition (Name of natory or other place	e) [	Date	20c. Location	- City or To	own, State
altin	permit. Page 1 a Department of H Important: If ite any injury or of	- 6	4 ☐ Donation 5 ☐ Othe (Specify)  2 Senature of Funeral Service Literage	n Cardon		Cremato  Name and Addres					Maryland al Home Inc
<u>m</u>	e e e e		23a Part 1 Enter the disease discomplic	MACHINACUS attended to the death. Do n	not ente		rk Road E			yland	
	Physician/	0.0	23a. Part 1. Enter the disease, of complica shock, or heart failure. List only one of Immediate Cause (Final disease or condition	parse on each line.	ما م	I w Ferre	) Co	и гезриатогу алт		13	Approximate Interval Between Onset and Death
- Ar	Medical Examiner		resulting in death)	Due to (or as a consequence	of):	un de	trese				
Λ.	ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury	Due to (or as a conse * ence	of):	)					
Þ.	be executed sician and burial-transit	cal Exa	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):						
3760	ficate be g physic as the b	Medic	d.							$\perp$	
. Box 6876(	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Jirector, After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the I	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknowh	If yes, outcome of pregnancy     1 ☐ Live Birth 2 ☐ Fetal death     4 ☐ Pregnant at time of death     9 ☐ Unknown		Ectopic pregnancy Other (specify)	/			ate of delivionth	ery Day Year
Division of Vital Records, P.O.	equires that the sen signed bould be deta	by	Part II. Other significant conditions contr	ibuting to death but not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did tol	\ 0		he cause of death?
Recol	ician: The law re certificate has bu rector, page 2 sh	Completed						24a. Was a autops perfor 1  Yes	sy	. Were auto prior to co death?	psy findings available mpletion of cause of 2 No
Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatien	Othe	r: 4 Nursing Ho		ence 6 🗆 Otl	her (Specifi	d)
n of	nding Phy th. : After thi s funeral o		27. Manner of Death  1 → Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury 28b.	Time of njury	28c. Injury work	at	28d. Describe ho			/
Divisio	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, stre	et, factory, office		28f. Location (St City or Town		per or Rural	Route Number,
	e Hospit 124 hour e Funera eleted fills	Medical	(Check 2 Medical Examiner	an: To the best of my knowledge, On the basis of examination and/o	or invest	igation, in my opinio	n, death occurred at	the time, date an	nd place, and di	ue to the ca	use(s) and manner stated.
	To the within To the comp		29b. Signature and title of certifier	NWO		29c. License			20d Date sign	ed (Month	Day Vearl
	12		30. Name and address of person who com		Type, P		Charles	ST	Buso.	N	10 2010 MP
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	0						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 2 Month Bay 7 2010 Physician/ 7:58p Ronald B. Williams Sr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris <u>Baltimore Co</u> Timonium 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** Days Min. 0970671940 1 ☐ M 2 ☐ F Months Hours 70 212-36-2497 Director Usual Residence of Decedent 10d. Inside City Limits show 10c. City, Town or Location 10a, State 10b. County Examiner must be notified at Director or 28a-f 1 XYes 2 No Baltimore MD N/A 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number permit, Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a of any injury or other traumatic event, the Medical Examiner must be Funeral 5651 B Purdue Ave. 21239 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes Give Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) S<u>teel Worker</u> <u>Bethleham Steel</u> 12th Grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harvey Williams Bevlal Hughes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) other) 5651 B. Purdue Ave., Baltimore, MD 21239 Janet Lavezzary(sig. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State Joseph Brown And Crematory 1 Burial 2 Kremation 3 Removal from State 『F^{/h} 12<u>/9/10</u> Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Funeral Service Ligensee Joseph Address of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, sician/ LUNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Exami this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 WILLIAMS, IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 X No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital filled in by the funeral director, Be Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\blacksquare$  Other (Specify) **HOSPICE** 2 X No မ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 24 hours after death. Funeral Director: After work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Wheeldal Examiner. To the basis of examiner and the story throwledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of Z0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

State Registrar

M DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December Physician/ loria 1097am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1 tomore Ospita Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 □X Months Hours Min. 03/ Director 237-72-9265 62 N.Carolina Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland al Hygiene. 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1603 Bakebury Ct 21217 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than mentary/Seconday (0-12) College (1-4 or 5+) the 12th Grade Janitor <u>Janitorial</u> Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Raymond Williams Dorothy Burroughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lataye M. Scott(daughter) 1828 Hope st., Baltimore.MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ARSecrementory or other place) H ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 12/10/10 Baltimore, MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last the attending physician and hed for use as the bunal-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery in the past 12 month 4 ☐ Pregnant at time of death g ☐ Unknown g 🗌 Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 Yes Hospital 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours a To the Funeral D Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier d cause of death (Item 23a) (Type, Print) 30. Name and address of person who complete 2000 9/45 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend \$25 & 77 per of 12/10/10 TT

Amend \$25 & Maryand Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Deconth 7^{Day} 20°TO 10:48P M Physician/ Mildred Wittan Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Arbor Place Adult Living Facility Rockville 7. Age (In yrs. last birthday) 87 yrs. if Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 1 ☐ M 2 🗓 F **Funeral** Days Maryland 06/01/1923 Director 216-16-2338 10d. Inside City Limits A Heath and Mental Hygiene Affect than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 25a or 28a-f show them 27 is marked other than "natural", or items 25a or 28a-f show them 27 is marked other than "natural", or items 23a or 28a-f show them 27 is marked other than "natural", or items 27a or 28a-f show that are also shown to the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10a. State Directo Rockville 1 🗌 Yes 2 🔀 No MD Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States Funeral 20853 4413 Muncaster Mill Rd. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ White 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Board of Physical 15. Decedent's Education (Specify only highest grade completed) Coffege (1-4 or 5+) Therapy Examiners - MD Elementary/Seconday (0-12) Director Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Hornstein Harry S. Tatelbaum ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) 33 Flints Grove Dr., N. Potomac, MD Joan Wittan / Daughter Department of Health Important: If item 27 any injury or other th 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Page 1 1 Burial 2 X Cremation 3 Removal from State Beltsville, MD Chesapeake Crematory 12/8/2010 4 Donation 5 Other (Specify) 21. Signature of Fineral Service Licensee Rapp Funeral and Cremation Services Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 3 Weeks Immediate Cause (Final Hip Fracture Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** years Alzheimer's Dementia Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine M Hypertension ysician and e burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last 0 Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be the t Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Year in the past 12 months? Month Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by 1 ☐ Yes 2 🌠 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has e 2 performed? Yes 2 A No 1 Yes 2 No after death.

Director: After this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 1 XNatural 2 Accident 5 Pending 2X No Slipped out of chair 7:00 P M 1 Yes Investigation 11/5/2010 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Rockville, MD 4413 Muncaster Mill Rd. 20853 3 ☐ Suicide 4 ☐ Homicide 6 Could not be determined Nursing Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 8, 2010 D0059137 MD address of person who completed cause of death (Item 23a) (Type, Print) Kelly Cowen M.D., 1201 Seven Locks Rd., Rockville, MD 20854 31. Date filed (Month, Day, Year) State 10 Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 20ÎÎ 9:49 PM JOHN ROBERT WHALEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** OCt. 29 Hours 1**X** M 2 □ F , 1939 Delaware Director 221-24-6612 Usual Residence of Decedent 10a. State 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Director 1 Yes 2 X No Harford Bel Air Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA Apt. B 21015 2302 Shoreham Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Rlack. White, etc. 1 Yes 2 No If Yes, Give þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) U.S. Government Boiler Tender permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumastra Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Virginia Hazel John Theodore Whaley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Pleasant Valley Lane, Brodheadsville, PA 18322 Claudia J. Cox / Sister in Law Baltimdre, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12-8-10 4 ☐ Donation 5 ☐ Other (Specify) Towson. Maryland Service Corp McComas Funeral Home, P.A. 317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Muocardia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Mitral the Hospital or Attending Physician: The law requires that the death certificate be executed valve that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1) labetes 24a. Was an has autopsy perform 1 ☐ Yes 2 ☐ No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Direct Medical 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Of State Of Registrar	Marylan		artment of F <i>tificate of L</i>			Jiene Reg. No.?	38955
	Physicia	ın/	Decedent's Name (First, Middle, Last)  CRAIG WARFIELD WOOD SF	·				2. Date of Dear	th	3. Time of Death 7:25 A
	Medic Examin		4a. Facility Name (if not institution, give street and numb			4b. City, Town, or	Location of Deati	DECEMBI	ER 9, 2010 4c. County of Dea	
آر	*		Gilchrist Hospice @ GE			Towson		.,	Baltimon	ce
	Funeral Director		5. Social Security Number $197304594$	. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year 9. Bin Co	rthplace (State or Foreign ountry) CyLand
	land show d at	tor	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-f	irec	Maryland Harford	Ве	l Air					1 🖾 Yes 2 □ No
	ith the 23a or st be r	ral	10e. Street and Number 905 Grayson Square			10f. Zip Code 21014	1		10g. Citizen of What Co USA	ountry?
	items	Funeral Director	11. Marital Status 12. Was Deced		3. 13. V	Vas Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. Race - Ame	
9030	urs after or ural", or I Examir	ed by	1 ☐ Never Married 2 【XMarried 1 ☐ Yes 3 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Date	2 XNo		Yes 2 No		o riicari, etc.,	Black, Whit	ve, etc. Vhite
15-(	72 hou n "nata Aedica	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give I	lent's Usual Occup kind of work done o O NOT use retired)	ation luring most of wor	rking	16b. Kind of Business	Industry
212	within giene. er tha t, the I		Elementary/Seconday (0-12) College (1-4	or 5+)	1	Equipmen	nt Operat	tor	County Gov	vernment
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, Last) Stanley Monroe Wood Sr.					me (First, Middle, N Lizabeth		
Aary	should and N is ma rauma	11.3	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number,	City or Town, State, Zi	ip Code)
e, N	and 2 Health tem 27		Janet Wood / Wife  20a. Method of Disposition	20b. P		Grayson S sition (Name of	Square, I	Bel Air,	MD 21014 20c. Location - City or	Town State
i mo	Page 1 nent of ant: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	C	emetery, cren	natory or other place n Cemeter	y 12-1			, Maryland
Baltimore,	permit. Departr Importa any inju		21. Signal of of Fundial Service/Lightsee		22	Marre and Address 1317 Coke	uneral F	Home, P.A	ngdon, Mary	.lond 21000
Е			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on each	used the death						Approximate Interval Between
	Priysician, Medical	ΪÍ	Immediate Cause (Final disease or condition resulting in death)			neer				Onset and Death
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	od sit	Examiner	rause Enter Underlying	as a consequ	ience of):					
	icate be executed physician and sthe buriat-transit	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or	as a consequ	ence of):					
200	rte be e hysicia he buri	edical	d							
687	ertifica Iding pl		IF FEMALE: 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes, outcomes 23c. If yes	me of pregna	ncy				224 Date of do	li
Division of Vital Records, P.O. Box 68	or Attending Physician: The law requires that the death certific first death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Completed by Physician/N	in the past 12 months?	rth 2 🗌 Feta int at time of d	l death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	Day Year
<u>P</u>	that th	by Ph	Part II. Other significant conditions contributing to dea		-	nderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds,	equires een sig rould b	eted	my clody splastic Sy	ndio	me			1 🗆 Ye	es 2 No 3 P	robably 4 🕅 Unknown
Reco	5 0 N	Comple						24a. Was ar autops perforr 1 \sum Yes	y prior to death?	ntopsy findings available completion of cause of
ţ	ician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2			Othe	ce of Death (Chec			10
of V	To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page?	ate: To	27. Manner of Death 28a. Date of	patient 2 injury Day, Year)	ER/Outpatien 28b. Time of injury	t 3 ∐ DOA 28c. Injury work'	4 Nursing H at	ome 5 Reside 28d. Describe ho	nce 6 Other (Spec w injury occurred	ify)(TOSPIEP
isior	· Attend er death rector: / by the f	Certificate:		Injury - At ho		M 1 L	Yes 2 ☐ No		reet and Number or Ru	ral Route Number,
<u>S</u>	pital or ours aft eral Dir filled in							City or Town		
	he Hos in 24 hr he Fun pleted	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the besis 3 Certifying Nurse Practioner: To	of examination	and/or investi	igation, in my opinio	n, death occurred a	at the time, date an	d place, and due to the	cause(s) and manner stated.
_	To t To tl		29b. Signature and title of certifier	2.		29c. License		_	9d. Date signed (Monti	h, Day, Year)
			30. Name and address of person who completed cause	of death (Item	23a) (Type, P		7063	2	12/2/10	
			Laura Patel 670	100	herrie		P 4605	Baltin	neve, MD:	21204.
	Stat Registra	_	31. Date filed (Month, Day, Year) DEC 1 0 2010	etrar's Signat	lire Kar					

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		State	te of Maryland	d / Depa		łealth and N	lental Hygi	ene	gible.	20056
Physicia		Registrar  1. Decedent's Name (First, Middle, Last)  Donald Reese Angles		<u> </u>	incate of L	<i>Jean</i>	2. Date of Death		20 ^Y PO	3. Time of Death 10:55 AM
Medic Examin		4a. Facility Name (if not institution, give street and Kline Hospice House	d number)		4b. City, Town, or Mount	Location of Death			ty of Death	k
Funeral Director		5. Social Security Number 6. Sex 1 図 M 2 [	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Feb. 7,	T956	9. Birthp Mary	lace (State or Foreign Tand
laryland 8a-f show ified at	ector	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgomery		Town or Loc					11	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the fv 23a or 26 ist be noi	Funeral Director	10e. Street and Number 11411 Kingstead Road		ame b c c	10f. Zip Code	879			f What Cound d Stat	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1  Never Married 2  Married  1  Never Married 2  Married 1  Yes	Decedent Ever in U.S ed Forces? Yes 2 X No s, Give or Dates.	If		spanic Origin? (Spe n, Mexican, Puerto Specify:		Bla	ace - America ack, White, e	etc.
/ithin 72 hour iene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade comp		(Give k life. DC	ent's Usual Occupa ind of work done d NOT use retired)	ation luring most of worki	ing 1		Business Ind	
ild be filed w Mental Hyg narked othe latic event,	To Be	17. Father's Name (First, Middle, Last)  John Joseph Angles					e (First, Middle, Ma ane Wingo		ne)	
nd 2 shouealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) Shane Angles / Son			-	ia Ave.,		-		
Page 1 s ment of H tant: If ite jury or ot		20a. Method of Disposition 1 怒 Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	from State Ce	mrestin	sition (Name of <b>at Weh</b> other place Gardens	e) Nov. 1 201	24,		i - City or Too Lck, M	wn, State aryland
permit Depart Impor any inj once,		21. Signature of Funeral Service Licensea		Re 95	Name and Addres Sthaven 01 Catoc	Funeral S tin Mount	Services, tain Hwy.	Skko Fred	t Cody erick,	P.A. MD 21701
Physician/ Medical Examiner			that caused the death on each line. L U C G e to (or as a conseq)	Car	r the mode of dying	g, such as cardiac c	or respiratory arrest	,		Approximate Interval Between Onset and Death Mon This
be executed sician and burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events  c	e to (or as a conseque e to (or as a conseque							
To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the beautiested filled in by the funeral director, page 2 should be detached for use as the bound in the funeral director.		in the past 12 months?	s, outcome of pregnan Live Birth 2 ☐ Fetal Pregnant at time of de Unknown	death 3 🗌	Ectopic pregnancy Other (specify)	у			ate of delive	ry Day Year
quires that t en signed b uld be deta	þ	Part II. Other significant conditions contributing	to death but not resu	Iting in the ur	derlying cause giv	en in Part I.				e cause of death?
<b>sician:</b> The law rec certificate has bee irector, page 2 sho	Completed						24a. Was an autopsy performe	- 1		sy findings available inpletion of cause of
hysician: nis certific I director,	To Be		1 ☐ Inpatient 2 ☐ E	R/Outpatient	Othe	ice of Death <i>(Check</i> r: 4  Nursing Ho	only one) me 5 □ Residen	ce 6樫Oth	her (Specify)	Hospice House
tending P death. tor: After the funera	Certificate:	Natural 5 ☐ Pending Accident Investigation Could not be	Month, Day, Year)	28b. Time of injury		Yes 2 No	28d. Describe how			
oital or Al		4 Homicide determined	Place of Injury - At hon ouilding, etc. (Specify)				28f. Location (Stre City or Town, S	State)		
othe Hosp thin 24 ho the Fune mpleted f	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the Check only one) 3 Certifying Nurse Practio	e basis of examination .	and/or investi	gation, in my opinion eath occurred at the	n, death occurred at time, date and plac	the time, date and e, and due to the ca	place, and di ause(s) and m	ue to the cau nanner as sta	se(s) and manner stated. ited.
F ≥ F 8		29b. Signature and the of certifier	D		29c. License	68104	290	a. Date signe	ed (Month, D	2010
3		30. Name and address of person who completed	cause of death (Item 2	Tra	$\Box \Box \Delta \Box$	e, free	deric	K, P	MD	21702
Stat Registra	-	NOV 3 0 2010	LENGTAN.	1.	parker	1.		*		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 1 Physician/ Dorothy Marie Boone 2010 ar 9:08 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring MD Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 5, 1937 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Days Hours 1 M 2 x F North Carolina Director 579 50 8222 73 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director DC Washington 1 ★ Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20019 United States 2126 Suitland Terrace, SE #302 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 Yes 2 No Specify: Specify: "natural" 3 🔀 Widowed 4 🗆 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mail Clerk US Postal Service 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rosevelt Bunch Elsie Armstrong permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12744 Gladys Retreat Circle, Bowie, MD 20720 Grandaughter Deborah Moore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cometery, crematory or other place) 1 🗗 Burial 2 □ Cremation 3 □ Removal from State 12/02/2010 Suitland, Maryland Washington National 4 Donation 5 Other (Specify) re of Fueral Service Licenses 22. Name and Address of Facility John T. Rhines Funeral Home LLC Sign 3005 12th Street NE Washington DC 20017 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Hemorrhagic Stroke disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🏄 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Yes 2 K No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No မူ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 24, 2010 D0064624 MD

Registrar
DHMH 17 Rev 7/2009

State

743 Summer Walk Drive, Gaithersburg, Maryland

20878

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

face

Sandeep Sharma
31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 20 To 125 A BAILIFF **JOSEPH** R. 6-Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crisfield Somerset 105 Columbia Avenue 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 08/16/1930 1 ☑ M 2 ☐ F Months Hours Min Pennsylvania 191-24-7537 80 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown winjury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Delaware New Castle Elsmere 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7 Locust Avenue 19805 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpet Installer Flooring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet E. McHugh (Daughter) 105 Columbia Avenue - Crisfield, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Glenwood Memorial Gardens: 11/30/2010 4 Donation 5 Other (Specify) Broomall, PA 21. Signatur 22. Narge and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, I H. Bradshaw, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Lamy agath Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 
 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate Yes 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Ďescribe how injury occurred Director: After 5 Pending work 1 🗌 Yeş 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 260-48

Registrar
DHMH 17 Rev 7/2009

State

351 Deershead Hospital - 2 North Wing - Salisbury,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Cowall, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROSINA BOJKO 28 10:30P M NOV 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL LUTHERAN HOME MONTGOMERY ROCKVILLE Social Security Numbe Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthdav) 9. Birthplace (State or Foreign **Funeral** GERMANY Months Hours Min. 12/28/ 94 1915 537-30-5470 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State lid be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MONTGOMERY BOYDS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15432 CONRAD SPRING ROAD 20841 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deces? Armed Forces? Yes 2 No Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. ō Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: WHITE "natural", 3 X Widowed 4 □ Divorced Year or Dates marked other than "natur matic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CAFETERIA WORKER PUBLIC SCHOOLS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည t. Page 1 and 2 should be f rtment of Health and Menta rtant: If item 27 is marked ijury or other traumatic e JOSEF MULLER MAGDALENA WENGERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELFRIEDE BORISOW GUARDIAN 15432 CONRAD SPRING ROAD, BOYDS, MD 20841 permit. Page 1 and 2.3 Department of Health Important: If item 27 any injury or other troope. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STAUFFER CREMATORY 11/30/10 FREDERICK, ervice Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician 111nar disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as 1 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death should be detached g Unknown Unknown signed by Part II. <mark>Other significant co</mark>ndi<mark>tion</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 performed? certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was c se eferred to ical 26. Place of Death (Check only one) examiner? Hospital: Other: ျှ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 47 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🔁 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SAMUEL

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

	10-08912 Terrance Alexan	der	PI Blackwell 1- For State	ease Ty S	pe or Print i ate of Maryl	and / Dep	artment	of H	lealth	ure and	All Co Menta	opies al Hyg	Are L	egibl	l <b>e.</b> 201	(1000)	33960
			Registrar  1. Decedent's Nan	00 (Eim)	lo Lost)	Ce	ertificate	of D	eath					Reg. No	)		
4	Physicia Medical Exami		Terrence	Alexa	nder Blaci	kwell_							Date of De Month Novemb	Day er 20,			3. Time of Death 1545 hrs
					on, give street and no Gracefield Roa				City, Tow Silver Sp		cation of	Death			lc. County o Montgorr		
3	Funeral		5. Social Security		6. Sex	7. Age (In yrs.	last birthday)		f Under 1		If Under	24Hrs.	8. Date of B		WDD/YYYY)		hplace (State or
74	Director		578-84-0	260	1X M 2 F	46		<u> </u>		Days	Hours	Min.		•	í	E	Washington
			Usual Residence										04/22	/190	04		DC
	w any		10a. State	10b. County		10c. Cit	y, Town or Loc	cation									10d. Inside City Limits
	yland -f sho	ector	MD		Georges	H	yattsvi										1 X Yes 2 No
	e Mar or 28a		10e. Street and Nu					10	Of. Zip Co					10g. Ci	tizen of Wha	at Coun	try?
	r death with the Maryland or items 23a or 28a-f show must be notified at once.	ral	11. Mantal Status	ess Cr	eek Drive	Apt. 3	02 JS   13 V	Vas De	2078	82 f Hisna	nic Ongin	2 / Spec	cify Yes or N	Jnit	ed St		San Indian, Black,
	death v	Funeral	1 Never Mam	ed 2 M	arried Armed F		10.0	f Yes, s	specify Co	uban, M	Mexican, P	uerto Ri	can, etc.)	10-	White,		an Indian, Black,
	after all, o	by F	3 X Widowed		orced If Yes, Give Yes	82/85	1[		s 2 X						Specify:	B1a	ack
	hours fratur				cify only highest grad		16a. Deced during	ent's U	Jsual Occ of working	upation life. D	(Give kin O NOT us	d of wor	k done	16b.	Kind of Bus		
	136 hin 72 e. than '	Completed	Elementary/Sec	ondary (0-12)	College (1	I-4 or 5+)							,				
	215-0036 be filed within 7 ntal Hygiene. -ked other than ent, the Medica	Con	17. Father's Name	(First, Middle,		<del></del>	Bart	end	er/ n			Name (F	irst, Middle		rivate Surname)	<u> </u>	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Be	William	B1ackw	e11					I	esli	e H	i11				
	D 21 should I ind Mer	ဥ	19a. Informant's Na							Street a	nd Numbe	er or Rur	al Route Nu		City or Town		
	, MD and 2 sho ealth and tem 27 is traumati		Angelia N 20a. Method of Dis	. Blac	kwell/ Da		11262 Place of Disp	2 Ex	Vans	Tra	il A		T2 Be		ville,		20705
	MOFe, Pages 1 an nent of He ant: If ite		1 X Burial 2	Cremation	3 Removal fr	om State	crematory or	other p	olace)				Jale	200.	Lucation - (	Jity Or 1	own, State
	ltim nit. Pa artmen ortand	-	4 Donation 5 21. Signature of Fu			Ft	Linc	o1n	Cem	eter	ry 1	2/1	1/2010	Br	entwo	od.	MD
	Baltil permit. Departm Importa	ļ	WIL	2	uned		134	01	Blad	eng	huro	Rd.	Linco. Bren	ln F	unera d, MD	1 Ho	ome 722
	Physician	ヿ	26a. Partyl. Enter the failure. List on	ne disease, or	complications that con each line	aused the death	n. Do not enter	the m	ode of dy	ing, suc	ch as card	liac or re	espiratory ar	rest, sh	ock, or hear	t	Approximate Interval
	Me Ji JI Examiner	1	Immediate Cause (	Final disease	Multir	le inju	ıries										Between Onset and Death
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		ē	Sequentially list co if any, leading to in	nmediate	Due to (or as a	consequence (	of):										
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	scuted and transit	ă	events resulting in	ueatii) Last	_ d	0011004001100											
		dica	X UNPENDED		AMENDED 2	7,28a-1	f. per	ME	0910	12	/16/	10 T	т				
	Box 68760, e death certificate be the attending physicied for use as the buri	₩.	IF FEMALE: 23b. Was decedent	pregnant in th	23C. II yes, t	outcome of preg	nancy							23	d. Date of de	elivery	
	x 68 n certif ending use as	ciar	past 12 months		Live	irth ant at time of de	anth -	etal de	eath (Specify)	3 <u></u>	Ectopic pr	egnancy	1		Month	Da	y Year
	BO)	Physician/Medic	1 Yes 2 1		nown 9 Unkno												
	Vital Records, P.O. Box 68760, visital: The law requires that the death certificate be exhibs certificate has been signed by the attending physician director, page 2 should be detached for use as the burial	P P	Part II. Other signi	ficant conditi	ons contributing to	death but not r	resulting in the	under	lying caus	se giver	n in Part I.		-	_	_	_	e cause of death?
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rather death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled in by the funeral director, page 2 should be detacled.											_					bly 4 Unknown
	COFC	Completed			<u> </u>								24a. Was		pric	or to co	psy findings available mpletion of cause of
	Re( The ficate												1 Yes	2 N		ath? Yes	2 No
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	of Vit ling Physic After this of	앍	1 ✓ Yes 27. Manner of Deat	2 No	28a. Date	of Injury	28b. Time of		1		4 Nork?	-			ince 6 🗸		Scene
	on endin ath.	[탈	1 Natural 2 Accident	5 Pend	ng 11/20	Day,Year)	3:29 p		1[		2 ^X No	pa	sseng	er i	n aut	o/a	uto
	visi or Att filter de Direct in by	Certification:	2 Accident 3 Suicide		not be 28e. Place	of Injury - At h	ome, farm, stre	eet, fac	ctory, offic	e buildi	ing, etc.						
	Di spital tours a neral I	8	4 Homicide		mined (Specify)	roadwa	ay					Gr	acefi	e1d	herry Road,	Si	Route Number, City 11 Road and 1ver Spring,
			29a. Certifier (Check only one)	Certifying Ph	ysician: To the best niner:On the basis o	of my knowled	ge, death occu	urred a	t the time	, date a	ind place,	and due	to the caus	se(s) an	d manner as	stated	
	To the within To the company of the the company of the the the company of the the the the the the the the the the	Medical	2 V 29b. Signature and		and manner st	ated.		ation, ii	29c. Lice			ed at the	e time, date				
		-	, ,	4						ense nu C.M.E					Date signed ember 21		n, Day, Year)
•		-	30. Name and addre	ess of person	who completed cause	e of death (Item	23a)		J.,		-			1,,,,,	J	., 201	
			Donna M. Vi			•	,	1 Per	nn Stre	et, Ba	altimore	, MD 2	21201				
	Sta		31. Date filed (Monti	n, Day, Year)	32. Res	gistrar's Signatu	ire Sack	v. 1	,								
	Registr	હા	UC	CO22	010 Denu	un D.	Back	230									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:40am 2010 Keaven Brooks November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Funeral 5. Social Security Number 6. Sex 1 🕅 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth Hours (Month, Day, Year) 01/20/1952 Director 577-70-6959 Washington. 58 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director DC Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 743 Decatur Street, NE 20017 u.s.A. should be filed within 72 hours after death w and Mental Hygiene. is marked other than "natural", or items : 12, Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No δ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify African-American 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Auto Clerk permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur Dalvin Brooks Laverne Moten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rachelle Williams - Sister 19523 Divot Place, Montgomery Village, MD 20886 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 11/29/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral & Cremation Win 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and us the burial transit Pulmonary Fibrosis that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, <u>Multi-Infarct, Dementia, Sickle Cell Anemia</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accider
3 Suicide 5 Pending 1 Yes 2 No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29b. Signature and title of certifier 29c. License number

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Duran.

24

Jonathan M.

31. Date filed (Month, Day, Year)

M.D.,

D66249

1500 Forest Glen Road, Silver Spring, Maryland 20910

November 19, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month BRINTZENHOFE COLA JEANNE 5:50AM Medical 10 Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death DR. 6310 JOHNSON DAMASCUS MONTGOMER 8. Date of Birth (Month, Day, Year) 6. Sex f Under 1 Year I If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 - M 2 X F 62 Director 214-52-5660 WNshow 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director FAIRFAX 1 Yes 2 No SPRING FIELD 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral Hillside Rd 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SMALL BUSINESS OWNER BUSINESS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ BRINTZENHOFE RICHARD 40000ALMA JEANNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #15 CHRISTOPHER SELARIO/SON 735 REED **JUA** SAN DIEGO, CA 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 2010 NATIONAL CREMATORY FALLS CHURCH, 22. Name and Address of Signature of Funeral Se Funeral Home mo1539 ,VA 22151 Springfield 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final Ph_sician/ metastases Esophagea CARCINOMA WITH disease or condition Medical resulting in death) Due to (or a a cons Examiner Sequentially list conditions, it is a least good in a solution cause. Enter Underlying Cause (Disease or iinjury Examiner Directly for as a pursuousness of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and signed by the attending physician and the detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29d. Date signed (Month, Dav. Year) 37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 355 PICCARD COLEMAN DRIVE SUITE 100 M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		Plea	ase Type or						-		_	le.	
	-	For State Registrar				rtment of tificate of		and N	vientai ny	Reg. No	2111	0	38963
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Medic Examin		4a. Facility Name (if not institution				4b. City, Town,	or Location of	of Death	11000		. County of i	Death	3.301
		9702 Highview 5. Social Security Number		7 0 //	lance to instruction of	Dama		0.4 Um	To 5 : (5)		Monte		
Funeral Director		220-60-4219 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. I	Yrs.	Months Days		Min.	8. Date of Bir Dec. 4	th ay, Ye <b>19</b>	17 N		ace (State or Foreign Land
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t. Page tment tant: I		4 Donation 5 Other (S	Specify)			Meth. C		cy 1	1/27/20	10	Damaso	cus,	Maryland
permit Depar Impor any in		21. Signature of Fundal Service	/ / /	liam	1/ N	. Name and Addr <b>loleswor</b>	th-Wil	Ĺliaı	ms P.A.	, Fu	neral	Hom	e
Ph_sician/ Medical	6 1	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	r complications that conly one cause on ea	aused the deat ch line. ementia	th. Do not ente	26401 Ri					Maryla		20872 Approximate Interval Between Onset and Death Years
Examiner an and ial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events resulting in death) Last	b. Due to (	or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or	uence of):								
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g Physer this eral die	e: To	1 ☐ Yes 2 ☐XNo 27. Manner of Death	28a. Date		28b. Time of	t 3 □ DOA □ 28c. Inju	4 ∐ Nu		ome 5 XResi			pecify)	
anding lath.	ficat	1 Natural 5 Pendir 2 Accident Investi	igation	h, Day, Year)	injury	Wo		- 1			,		
To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completed filled in by the fun	al Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place buildir	ng, etc. (Specify	/)	eet, factory, office			28f. Location (S City or Tov	vn, State)			
ne Hospi in 24 hou ne Funer pleted fil	Medical	(Check 2 L Medical E	g Physician: To the b Examiner: On the bas g Nurse Practioner:	is of examinatio	n and/or invest	igation, in my opir	iion, death oc	ccurred a	t the time, date a	and place	, and due to	the caus	se(s) and manner stated.
To the common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common common co		29b. Signature and the of certifier	1) 0	ì		29c. Licen	se number			29d. Dat	te signed (M	onth, D	ay, Year)
		125	1 ohn			D20	148			Nov	ember	23,	2010
3		30. Name and address of person Steven Doli				_{rint)} 1 Avenue	, Ga	ithe	rsburg,	Mar	vland	20	1879
Stat Registra		31. Date filed (Month, Day, Year)	32. B	eg strar's Signa		bare			,		,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended line 19a per FH/tlv Continued of Death Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bruce Milton Brandenburg Physician/ November 23 10:20 P M 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. ial Security Number **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F 216-14-5138 90 11/9/1920 Country)
MD **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director MD Frederick Middletown 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 321 S. Jefferson St. 21769 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 X Married Yes 2 XNo Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White "natural", Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) federal Elementary/Seconday (0-12) College (1-4 or 5+) government technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leslie Brandenburg Annie Waters et and Number or Rural Route Number, City or Town, State, Zip Code) 21769 Middletown Rd., Middletown, MD 19a. Informant's Name/Relationship (Type, Print) (Daishter-in-Daughter-in-law Kathy Miss Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State Lutheran cemetery 11/29/2010 Middletown, MD □ Donation 5 □ Other (Spec)(y) ure of Furer a Service Li Sign 2DomanddreBof FaThompson Funeral Home Ε. Main St., Middletown, MD Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPIRATION Premowia Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Congestive Herry Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HORTOU STENOSIS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed been 8 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed this certificate 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🖵 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) funeral 27. Mann<del>or</del> of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 Natural 5 Pending work Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State Registrar

10

Cualul

asel4 30 Name and address of person who completed dause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Amended #17 per FH, RG FCHD 11/30/10

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month November 2010 8:20 A.M Mary A. Biser Medical 4a. Facility Name (if not institution, give street and number) Glade Valle 🕫 b. City, Town, or Location of Death Examiner 4c. County of Death Nursing & Rehabilitation Center Walkersville Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Yea Director 219-14-8575 MD Jan. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖾 No MD Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral <u>5266 Mountville Road</u> United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Armed Forces?
1 ☐ Yes 2 ♣ No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 Midowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mary M. Delauter J. EZRA MERCER Joseph E. Mercer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5266 Mountville Road, Adamstown, MD 21710 19a. Informant's Name/Relationship (Type, Print) Brenda Wilhelm-daughter 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory 11/22/2010 Frederick, MD Signature of Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Homes, P.A. فالما 1621 Opossumtown Pike, Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive heart failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Yea ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 🗌 Yes 2 → No 3 □ Probably 4 □ Unknown iis certificate has been si director, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural
Accider
Suicide  $5 \square$  Pending injury Accident Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

istrar's Signature

a state of the

Thomas Thousand

Fredorick mo difez

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

sheh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov. 2010 27, 8:20 Рм E11en Ε. Blandford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 13810 Edelen Dr. Bryantown Charles Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days (Month, Day, Year) (ulv 28,1915 1 🗆 M 2 😿 F Hours Min 218-38-8733 95 **Director** Maryland Usual Residence of Decedent 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Charles Maryland 1 Tes 2 No Bryantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 13810 Edelen Drive 20617 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2X No Yes, Give Maryland 21215-0036 1 Yes 2 XNo Specify White Specify: Completed 3 ₩ Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked of Pinkney A. Earnshaw, Sr. : If item 27 is marke or other traumatic Bertha M. Reec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 13810 Edelen Dr., Bryantown, MD 20617 Mary E. Wells/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Mary's Piscataway 12/2/2010 Piscataway, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 MOO817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 Who Month Day Year signed by the a d be detached fi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, paga ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 W/No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5XXResidence 6 Other (Specify) 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Rme erson who completed cause of death (Item 23a) (Type, Print

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Mont)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 03 :01 AM November Virginia avio Mary Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Agnes Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Days 87 Maryland Director May 16, 1923 220-12-3922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rotified at once. 10d. Inside City Limits 10h County 10c. City. Town or Location 10a State 1 Nes 2 No Director Baltimore Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21229 4104 Edmondson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∏Yes 2 X No Specify: Specify: Black þ 3₺ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glass Manufacturing 12 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Jared Jameson Fannie Wilson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Joyner / Daughter 3710 Ferndale Avenue, Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Saints Episcopal 20c. Location - City or Town, State 20a. Method of Disposition Date December 4. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2010 Avenue, Maryland Cemetery Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Fun@ral Service Ligense 22. Name and Address of Facility P.O. Box 270, Leonardtown, MD 20650 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burlal-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Preumothorax (Bilateral) Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Ulcer infection with ESBL Klebsiella 10 yes certificate Decubitus 2 1 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To After this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after deam.

To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P 25479 November 28, 2010 . Masheyelst )erre 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 South Caton Avenue, Baltimore, MD 21229 AMENEH MASHAYEKH. 31. Date filed (Month, Day, Yea 32. Registrar's Signature State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State of Maryland / Dep State Of Registrar	ertificate of Death	Reg.	2010 20060
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month December	Day 2010 3. Time of Death 1:00 p.M
	Medic Examin	al	Sonja Marie Bailey  4a. Facility Name (if not institution, give street and number)	4b, City, Town, or Location of Death		T', 2010 1:00 p.M
		Ŭ.	St. Mary's Nursing Center	Leonardtown		St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	if Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 11/01/195	9. Birthplace (State or Foreign Country)
	Director		151-28-6762 73 Yrs. Usual Residence of Decedent		11/01/195	37   Pennsylvania
	f shoved at	tor	10a. State 10b. County · 10c. City, Town or L	ocation		10d. Inside City Limits
	e Mar r 28a- notifie	Direc	Maryland St. Mary's Lexing	gton Park		1 Tyes 2 No
	with th	Funeral Director	46657 Yorktown Road	20653	10g.	Citizen of What Country? USA
	death items		11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
336	s after al", or Exami	d by	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.	1 ☐ Yes 2X No Specify:		Specify: White
2-0	hours 'natur dical	Completed	15. Decedent's Education 16a, Dec	edent's Usual Occupation e kind of work done during most of worki	166	b. Kind of Business Industry
Maryland 21215-0036	thin 72 ane. than '	mo	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)	ng .	O Homo
Q 7	led wii Hygie other ent, t	Be (	12 Hom 17. Father's Name (First, Middle, Last)	emaker  18. Mother's Name	e (First, Middle, Maid	Own Home
/lan	d be fi Mental arked itic ev	욘	Richard W. Weller	Mildred	E. M.	agnusson
<b>Jan</b>	should and b			ling Address (Street and Number or Rura	· ·	· ·
	and 2 Health tem 2		Herbert Bailey/Spouse 466 20a. Method of Disposition 20b. Place of Disp	57 Yorktown Rd., L		Park, MD 20653
mor	Page 1 lent of nt; If ii ry or c		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place)		clington, VA
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sig. part of External September Licenses	22. Name and Address of Facility Bri	insfield F	Guneral Home, P.A.
ш	0 0 = # 0		Edward N. Brinsfield, Jr. M00052  23a. Part 1. Enter the disease, or complications that caused the death. Do not er	22955 Hollywood Rd		
	e Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying, such as caldiac o	i respiratory arrest,	Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)  a. Due to (1 as a consequence o):	OD =		
	Examiner	-E	Sequentially list conditions, b. Room State 4	Nuc.		
	ted nsit	Examiner	Sequentially list conditions, it may had be to made to cause. Enter Underlying Cause (Disease or imjury			
	icate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last  C. Due to (or as a consequence of):			
3760	ate be hysicii the bu	edical	Ld. COPS			
687	:- 70 02	/Me	IF FEMALE: 23b. Was decedent program: 23b. Was decedent program: 23c. If yes, outcome of pregnancy			CO.d. Date of delivery
XOX	death certif ne attending ed for use a	Physician/N	in the past 12 months?  1 Use Birth 2 Fetal death 3 1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
P.O. Box	es that the des signed by the s be detached 1	Phys	g Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	us destricts across since in Destrict		
ν. σ.	res tha signed	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
ord	require been signification	olete			24a. Was an	24b. Were autopsy findings available
Sec.	The law ate has bage 2 a	Completed			autopsy performed 1 \(\sum \) Yes 2 \(\overline{L}\)	prior to completion of cause of death?
tal	ding Physician: The la th. After this certificate ha funeral director, page	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		1100 / 2 100 / 2 100
Ž	Physion this contral direction	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 28a. Date of injury 28b. Time	,	me 5 Residence	e 6 Other (Specify)
o uc	nding ath. r: After e fune	icate	1 Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident □ Investigation	work?  M	zod, Describe now if	ijury occurred
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Certificate	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
Ö	Hospital of the spiral of the		29a. Certifier 1. Certifying Physician: To the best of my knowledge, death	a popured at the time, date and place, as		
	To the Hospital or within 24 hours aft to the Funeral Dir completed filled in	Medical	(Check only one) 3 Certifying Practioner: To the basis of examination and/or inve	estigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the cause(s) and manner stated.
	Vithi Voth		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	}		May degruent	DOO 10900	) [2	40210
) R	me		30. Name and address of person who completed cause of death (Item 23a) (Type, 2007 Trdowoder Of One Dr. Anno	polis, MD 214	01	
	Sta		31. Date filed (Month, Day, Year)  DEC 0 3 2010  Acres 1. 32. Registrar's Signature	have		
	Registra	ar	DLU V D ZUTY REMOVE P.	gran		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nov 30. 2010 Christine Cottrill 11:57 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 728 Baker Street Cumberland Allegany 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 1 🗆 M 2 🗆 😿 5^{ar)}1950 Hours Dec 16, Director 214-48-3224 59 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits the Medical Examiner must be notified at Funeral Director MD 28a-f Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 728 Baker Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 'natural", Specify: 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည William D. Carroll Helen Frances (Miller) Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Gary Carroll brother P.O. Box 603 Fort Ashby WV 26719 item 27 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important; If it any injury or o once. cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State 12/3/2010 Flintstone MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par. 1. El ter the liseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atheroselerotic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to inmediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence off. To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Yes 2 No 9 Unknown 9 Onknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? 1 ☐ Yes 2 ☐ No 2 E 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Tes 2. No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural (Month, Day, Year) 5 Pending 1 Yes Investigation 6 Could not be 2 Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) edical Certifying Physician: To the bes∜of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: 76 the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: 76 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year, NOVEMBER D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 SETON DRIVE CLUMPEPLAND, MD 21500 POONALM.D. 32. Registrar's Stonatur 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of	Marylan		artment rtificate			and M		giene Reg. No.		389	70
Physici	an	1. Decedent's Name (First, Middle,	Last)		<u>-</u>					2. Date of De. Month	Day		3. Time of	Death
/Media	cal	MAXINE AMELIA				45 035 7	roum or	Location	f Death	11/17		County of Deat	0330	M
Examir	ıer	4a. Facility Name (If not institution, PRINCE GEORGE S	•		2		ERL	Location o	n Death			RINCE GE		
Funeral			6. Sex	7. Age (In yrs.		If Under	1 Year	If Under	24 Hrs. Min.	8. Date of Birl (Month, Da	th	9. Birt	hplace (State o	r Foreign
Director		178-36-3231	1 □ M 2 🔀 F	65	Yrs.	Months	Days	Hours	194311.	4/14/1			tcheste	r,PA
and ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Ci	ty Limits
Mary Ind	tor	Maryland Prince	George's	Cap	itol H	eight:	s						1 [XYes	2 🗌 No
th the	Jirec	10e. Street and Number	0002,00			10f. Zip					10g. Citi	zen of What Co	ountry?	
23a unit	rai	7308 Shady Gler					743				US.			
I and 2 should be filed within 72 hours after deeth with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show other traumatic event, the Maryland Examiner manual be netilized at	by Funeral Directo	11. Marital Status  1 □ Never Married 2 □ Marrie  3 □ Widowed 4 ▼ Divorced	Armed For	2 <b>∱</b> No e		Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit Specify:		
2 hou		15. Decedent's	s Education		16a. Dece	dent's Usua	l Occupa	ition	t af warki	na	16b. K	ind of Business/		
ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of wor DO NOT us	e retired,	)	OF WORK	ng .				
lled w dygier ther th		12 17. Father's Name (First, Middle, L	6		Educ	ator		18 Mothe	r's Nama	(First, Middle,		. Count	y School	ls
d be file	o Be	Hollander Doorl						Mari			, maioon	Carrianity		
2 should and Men le marke	2	19a. Informant's Name/Relationsh			19b. Mailir	ng Address	(Street a				er, City o	r Town, State, 2	Zip Code)	
and 2 aalth a aalth a er tra		Richard Cooper	/ Son						Balt	imore,	Md.	21218		
permit. Pages 1 and 2 Department of Health s Important: If I tem 27 is any injury or other tra		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 ∏Removal from 5	20b. P	lace of Dispo emetery, crei	nsition (Name	ne of ther place	9)		ate		ocation - City or		
Pag tment tant:		4 ☐Donation 5 ☐ Other (Sp	ecity)	Ri	verdal 			i		/2010		erdale,		
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service L	icensee	W NI S								omes, P		7/7
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pu inter		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final					J 0. 0,	, 000					Interval Bet Onset and I	ween Death
Physician /Medical	1	disease or condition resulting in death)		RATORY :		E								
Examiner		Sequentially list conditions,	b. SEPSIS	3										
pe #s	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (	or as a conseq	uence oly.									
and and II-tran	Examiner	that initiated events resulting in death) Last	c. PNEUMO	ONIA or as a conseq	uence of):									
e be ex	ical E		d COPD	<b>,</b>										
ifficate g phys			0. 0012											
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☒ Unknown		inth 2 ☐ Feta ant at time of d	death 3[	Ectopic pre Other (spe		- 3345				23d. Date of del Month	,	Year
w requires that been signed be should be deta	þ	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the u	nderlying ca	ause give	on in Part I.				use contribute to	_	
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Or VICAL Physician: This certifice	Be	25. Was case referred to medical examiner?	Hospital:				. 04			Check only				
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Attending or death.	ition	1 XNatural 5 ☐ Pending 2 ☐ Accident investig.		of Injury h, Day Year)	Injury	М	8c. Injury Work 1 🗆 `	(? Yes 2 🔲 :				,		
el or Atter s efter dea al Director	Certification:	3 Suicide 6 Could n 4 Homicide determin	288. Place	of Injury - At hong, etc. (Specif	ome, farm, sti y)	reet, factory	, office			28f. Location ( City or To	Street ar wn, State	nd Number or Ri	ural Route Num	ber,
he Hospitel or n 24 hours efte he Funeral Dir pletely filled in	edical	29a. Certifier 1 ☑ Certifying (Check only one)	Physician: To the examiner: On the ba and mann	asis of examina	wledge, deat tion and/or in	h occurred a vestigation,	at the tim in my op	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s date and	and manner as d place, and due	s stated. e to the cause(s	;)
To the Vithin 2 To the comple	Σ	29b. Signature and title of certifier	in /	20	`	29c	License	number			29d. Da	te signed (Mont	th, Day, Year)	
2		· gour	V.Sc	ON			DZ	15	11		11/	17/10		
4		30. Name and address of person v						.1	· • • • • • • • • • • • • • • • • • • •	lam 1 00	705			
Sta	ite	Ophnell Cumberb 31. Date filed (Month, Day, Year)				ve Ch	ever	ту, Г	mary.	land 20	/85			
Regist		NOV 2 9 2010	Deser )	B. A.	sie.				i.					

DHMH 17 Rev 1/2001

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			For State	State of Maryland				d Mental Hy	/giene		
		-	Registrar  1. Decedent's Name (First, Middle, La.	st)		rtificate of	Dealli	2. Date of D	Reg. No.	1-9-	3 8 9 7
	Physic		BUD ANDREW COLL	•				Month 11	Day 23	Year 2010	0840Am
21	/Medi Examii		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of De			nty of Death	00 7011
			30391 Pine Street			Princes	s Anne		Sc	omerset	t
	Funeral		5. Social Security Number 6. S	TM 2 TF	birthday) Yrs.	If Under 1 Year Months Days		frs. 8. Date of Bi fin. (Month, D	rth ay, Year)	9. Birthpl Count	lace (State or Foreign
-	Director		236-46-1965 Usual Residence of Decedent	79	115.			03-01	<u>-1931</u>		West Va.
	yland Jow at		10a. State 10b. County	10c. City, To	own or Lo	ocation				10	0d. Inside City Limits
	e Mar ka-f sl tified	ctor	MD. Somerse	t Pri	nces	s Anne					1 Pres 2 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Coun	try?
	s 23a	<u>ra</u>	30391 Pine Stree		1.0		.853		U.S.		
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No /-05- If Yes, Give Year or Dates: /-/5-5	3/	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? an, Mexican, Pe Specify:	(Specify Yes or Nuerto Rican, etc.)	o- 14. H B	lace - America lack, White, e cify:	
20	72 hornatur	eted	15. Decedent's Ec (Specify only highest gra	ducation 10		dent's Usual Occup		warking	16b. Kind of	Business/Ind	lustry
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an	ould be Mental arked o	To Be	Morris Collins					na Smith		,	
Maryland	should and Men is marke	-	19a. Informant's Name/Relationship (	Type. Print) 1	9b. Mailir	ng Address (Street					Code)
	1 and 2 Health a tem 27 is		Barbara Lee Co			l Pine St		ncess Ann	e, MD.	218	353
Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Bernoval from State	of Dispo	sition (Name of matory or other plac	re)	Date	20c. Location	n - City or To	wn, State
Ë	Pag tment tant: jury o		4 ☐ Donation 5 ☐ Other (Specify	W) Easte		hore VET.		11-29-20	10	Hurloc	k,Md.
Bal	permit. Pag Department Important; If any Injury o		21. Signature of Funeral Service Licer	/ M00295	- 1	2. Name and Address 1673 Some	•		Funera cess An		
68760,	The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ledical Examiner	23a. P. 1. Enter the disease, or com hock, or heart failure. List only lmn diate Cause (Final disease or condition multing in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (or as a consequence)   e of):	1001 1 to :		ailme		7	Approximate Interval Between Onset and Death	
P.O. Box 6	the death certific r the attending p ched for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			1	Date of deliver	ery Day Year
	w requires that the de been signed by the s should be detached t	þ	Part II. Other significant conditions of	ontributing to death but not resulting	g in the u	nderlying cause give	en in Part I.				ably 4 \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \textstyle \tex
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Division	는 e e	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location City or To	(Street and Nur wn, State)	mber or Rural	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (	29a. Certifier (Check only one)  1 ☑ Certifying Ph 2 ☐ Medical Exam	ysician: To the best of my knowled niner: On the basis of examination and manner stated.	lge, deatl and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the ccurred at the time	e cause(s) and , date and plac	manner as sta e, and due to	ated. the cause(s)
	To the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the company of the	Ž	29b. Signature and title of certifier			29c. License		-3185	29d. Date sign	ned (Month, L	Day, Year)
<b></b> ≺`	1341		30. Name and address of person who	NADACTNIL	£	Print)	AVE	117	1	1	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature		71	INC.	4/)			
	Registr		NOV 2 9	32. Registrar's Signature	A. ,	parke					
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Nan Jacqueline Cannon 4.35 AM 2010 NOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Politicent River Health and Rehab Prince George S Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/28/1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 1 F Months Hours Min. New York, NY 130 24 1411 81 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "notice..." 10c. City, Town or Location 10a, State 10b Counts 10d. Inside City Limits Director 1√ Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5361 Brookway, apt.#4 21044 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify: Specify: Black <u>Ş</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Seamstress Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leo Cannon Sr. Emily Duncan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo Cannon III Nephew 6302 Hilmar Dr., District Heights, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/23/2010 Beltsville, MD Chesapeake Crematory 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John T. Rhines Funeral Home LLC 21. Signature of Funeral Service Licenses BOO5 12th Street, NE Washington, DC 23a. Part1. Enter 1. dise, se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart all ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** montes -aliuve to 15 nive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner AIDS Years Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician

Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 Unknown Completed by

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. antery Coronory disease

28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown

Cerebro vasuelos accident Atrial fibrillation

performed? Yes 2 2 No 1 □ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Natural

5 Pending investigation 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Sherady

autopsy

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

(Check only

2 Accident

29a. Certifier

29c. License number D 53411

Bowie

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29d. Date signed (Month, Day, Year) Nov 2010

Registrar

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death, I hours after death, uneral Director: /

To the Hospital within 24 hours a To the Funeral L Hospital

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Certification: To

Medical

Gallant Fox 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 F 210 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
#5 Per FH G910 12/22/10 Jh
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ronald D. Colbert November 2010 11:48 a^M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Sept. 15 If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign 1X□ M 2 □ F Months Days Hours Min. Bethesda. Director 58 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1131 University Blvd. West #418 20902 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sport Journalist UPT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I-Important; If item 27 is marked or any injury or other traumatic even ٥ John A. Colbert Velora Redmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Johnson / Sister 711 Newton Pl. N.W. Washington, D.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Glenwood Cemetery 11/30/2010 Washington, D.C. 22. Name and Address of Facility
Alexander, S. Pope. / P
5538 Marlboro Pike/ Signature of Funeral Service Licen  $\dot{\mathbf{F}}_{\mathbf{orestville}}^{\mathbf{A}}$  in  $\mathbf{M}$ 20747 23a. Part 1. Ehter the disease, of complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ 1/4 on disease or condition resulting in death) Medical Due to (ork s a constituence of) Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or linjury Examine or as a consequence of Fuilure or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dedetached for use as the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 🔀 No 은 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: Date of injury 28b. Time of s after death. I Director: After t 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

Date filed (Month, Day, Year)

NOVE 4 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32, Registrar's Signature

Kinnain

D68658

18101 Prince Philip Dr. Olney, Md.

29d. Date signed (Month, Day, Year)

20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0330 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Victor Alexander Courie Medical 0 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 3 Rockville Shady Grove Adventist 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days Hours Min. (Month, Day, 8 / 1 5 / 1 🔀 M 2 🗆 Director 579-38-4004 84 Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location Director NOVEMBE MD Montgomery Potomac 10e. Street and Number 10f. Zip Code Funeral 20854 10714 Potomac Tennis Lane 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1945
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) δ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 Divorced 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical ررا 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Cours Elementary/Seconday (0-12) College (1-4 or 5+) Health and Mental Hygiene. tem 27 is marked other tha Deputy Director Be 17. Father's Name (First, Middle, Last) Alexander F.Courie Victoria Aed 19a. Informant's Name/Relationship (Type, Print) Linda V.Courie/Niece Page 1 and 2 Defmit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) ate of Heaven Mausoleum 1 Burial 2 Cremation 3 Removal from State Gate 11/23/2010 4 Donation 5 M Other (Seath ombment of Funeral Servi 🥡 ice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ cardio arrest monan pul ) Medical resulting in death) Due to (or as a consequence of): Examiner tailure Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last notension Due to for as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an performed Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 ℟ No Other: Certificate: To 1 🔲 Yes 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 29b. Signature and the of certific 29c, License number 0067512 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bangalore Madan 9901 Medical MD 31. Date filed (Month, Day, Year) State

3. Time of Death Nov. 20, 2010 0330 4c. County of Death Montgomery 9. Birthplace (State or Foreign 1926 Wash. , DC 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14 Race - American Indian Black, White, etc. White Specify: 16b. Kind of Business Industry Department of U.S.Air Force 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1189 N. Vernon Street Arlington, Va. 22201 20c. Location - City or Town, State Silver Spring, MD PHILIPADSRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) November 20, 20,0 center Drive, Rockiville, Maryland 20850 2 4 2010

Registrar

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-	Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. last I	birthday)	If Under 1 Year	If Under 2		. Date of Birt	h	9. Birth	place (State or Foreign	$\dashv$
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Juneral Service	Liberties MO1	315	22. Name and Address of Facility DeVol Fur 2222 Wisconsin Ave., N.W.							0000	
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	To the Hospital or Attending Physician: The law requires that the within 44 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	(Check 2   Medical	ng Physician: To the best of I Examiner: On the basis of e	d/or investi	igation, in my opinic	n, death occ	curred at the	time, date a	nd place,	and due to the ca	iuse(s) and manner stated	d.	
	To the Hos within 24 h To the Fun completed	ž	only one) 3 Certifyir 29b. Signature and title of certifi	ng Nurse Practioner: To the	owledge, d	eath occurred at the	e time, date	and place, a	and due to the	cause(s	and manner as signed (Month,	tated.	$\dashv$	
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				AMIM, MD								_		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 12/3/10 AMENDED 4C Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11/25/2010 BETTY A. COHO Medical 12:36 P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death DORCHES THE WILLIAM HILL MANOR **EASTON** 5. Social Security Number **Funeral** 6. Sex Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 6/26/1924 1 ☐ M 2**X** F Months Days Min. Director Country) NEW YORK 112-14-3365 86 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a, State 10b. County within 72 hours after death with the Maryland Funeral Director 10c. City, Town or Location 10d. Inside City Limits MARYLAND TALBOT 1X Yes 2 ☐ No **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 BELGRAVE CT. 21601 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 0. þ Black. White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2X No Specify: Completed 3 - Widowed 4 - Divorced Year or Dates WHITE traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work dane during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MANAGER 4 REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **ROLLO BRADLEY ANNIS EDNA HENRY** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any injury or other tr A. BRUCE COHO / SON 720 SHROPHIRE DR., WEST CHESTER, PA 19382 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place MID SHORE CREMATION CENTER BY COLLEEN CURRAN-BROMWELL, P.A. 4 ☐ Donation 5 ☐ Other (Specify) 11/29/2010 CAMBRIDGE, MD Signature of Funeral Sep 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Onset and Death CARDIOMYOPATHY disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying for use as the bunal-trans Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death Month 5 Other (specify) Day Year signed by the a 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by H BRILLATION HYPERTENSION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes Accident Suicide Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State

Box 68760 P.O. Records, within 24 hours are comments the Funeral Director. After this certified Division of Vital To the Hospital or Attending

CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST. CAMBRIDGE, MD 21613 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ATTENDING MD Name and address of person who completed cause of death (Item 23a) (Type, Print) MD MI SLOOMING & Date filed (Month, Day, Year) **ORIGINAL** 

Registrar DHMH 17 Rev 7/2009

State

Medical

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		Please Type or Print in Black			•	•	
	_	For State of Maryland / De	•		ilentai Hyg	iene	38977
		Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of <i>E</i>	<i>Death</i>	2. Date of Deat	eg. No.	1
Physicia		Alvin Eugene Chalk			Month, November	Day Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	NO V CINDE I	4c. County of Death	
	-	11703 Serene Court	Mor	nrovia		Frede	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9 Rirtl	nplace (State or Foreign
Director		577-40-5896 1 ■ M 2 □ F 79 Yrs.  Usual Residence of Decedent			oct.24,	1931   Ma	ryland
and show	2	10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
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a or 2	iO IE	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What Cou	untry?
h with	Funeral Director	11703 Serene Court		21770		U.S.A	•
r deat r iten iner		11. Marital Status  1 □ Never Married 2 ■ Married  12. Was Decedent Ever in U.S. Armed Forces?  13. Was 12 □ No1 951 −  14. Was 2 □ No1 951 −	<ol><li>Was Decedent of His If Yes, specify Cuba</li></ol>	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
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ould bud Me mark		George E. Chalk  19a. Informant's Name/Relationship (Type, Print)  19h Mi	piling Addrago /Street s	and Number or Dune	Lois Bo	XWell City or Town, State, Zip	(C-1-)
12 sh alth ar 27 is r trau			)3 Serene (		•		Codej
1 and 1 and of Hear item		20a. Method of Disposition 20b. Place of Dis	sposition (Name of			20c. Location - City or	Town, State
Page nent c		Danial 2 - Ordination o - Nethoval noth State	rematory or other place oln Cemete	′ !	27,2010	Brentwood,	Marvland
permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inpopratment of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Addres	s of Facility	ma D A	, Funeral	Hama
		Marine a district the city	254U1 R1c	ige Road.	Damascu	s. MD 208/	2
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Physician/ Medical		resulting in death)	Cancer				Onset and Death 2 Years
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or into	restigation, in my opinio	<ul> <li>n. death occurred at</li> </ul>	the time date and	Inlace and due to the c	ause(s) and manner stated
To the within To the Comp	2	29b. Signature and the of certifier	29c. License			9d. Date signed (Month,	
		I felle to she emo	D2	1910		November	24,2010
		30. Name and address of person who completed cause of death (Item 23a) (Type					
10+1VA		Dr. Peter Sherer, M.D., 3921 Ferra 31. Date filed (Month Paryles) 0 0010 32. Resistrar's Signature	ra Drive,	Wheaton,	MD 2090	6	
Stat Registra	e ir	31. Date filed (Month NOV) 9 2 9 2010 32. Rysistrar's Signature	parked				3
HMH 17 Rev 7/20							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 11-17-2010 Coates Annie 4:20p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles County Rehab. Center Charles LaPlata If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 – 25 – 1932 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1□ M 2 F Months Days Hours Min 78 218-54-6744 Marvland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1⊠Yes 2 No Maryland Charles Bryantown 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5655 Ted Bowling Rd Funeral 20617 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2 No Specify ð 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+ Domestic Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George P Frances ပ G. Butler Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward S.Coates/Husband 5655Ted Bowling Rd, Bryantown MD 20617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St.Marys 4 ☐ Donation 5 ☐ Other (Specify) 11/22/10 Bryantown Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Theren Venl Adams Funeral Home Pa, Aquasco Md 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final erebra disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conse guence of Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 1 ☐Yes 2 No 5 Other (specify) o∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🕱 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760,

Physician; The law requires that the death certificate be executed and burial-tra attending physician for use as the buria the ģ signed I has page 2 : certificate director. this funeral After or Attending within 24 hours after deatl To the Funeral Director: Hospital

**Funeral** 

Director

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Department of Health as
Important: If item 27 is
any injury or other trau

**Physician** 

/Medical

Examiner

The Medical

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

233

Medical

Fatima 31. Date filed (Month State

4 Homicide

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as sales.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allentown Rd. #101, Camp Springs, MD

32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year Physician/  $P^{M}$ 5:55 Aloysius Connelly James lovember 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Leonardtown St. Mary's St. Mary's Hospital 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 1 🖾 M 2 🗆 F Director 217-64-8524 57 September 6, Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No St. Mary's Leonardtown Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral 41275 Medleys Neck Road 20650 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Naval Aviation 12 <u>Materials</u> Expiditer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ James Alan Connelly Agnes Henrietta Abell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Alan Connelly / Father St. Johns Road, Hollywood, MD 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date December 7, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Aloysius Cemetery Leonardtown, Maryland 2010 ture of Funeral Service Licen Mattingley-Gardiner Funeral Home, P P.O. Box 270, Leonardtown, MD 20650 22. Name and Address of Facility Jardin Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final roside adenocarcinoma Physician Advanced disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 18 months Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Yes 2 No 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5  $\square$  Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 To the within 2 To the I comple only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d, Date signed (Month, Day, Year) D20177 December 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(g) production State

Registrar
DHMH 17 Rev 7/2009

Krishna P. Jayaraman, M.D.,

31. Date filed (Month, Day, Year)

DEC 0 1

32. Registrar's Signature

28227 Three Notch Road, Mechanicsville, MD 20659

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:00 P M Mary Elizabeth December 2010 Chase Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 40459 Parson Mill Road St. Mary's Loveville Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 08/15/192 88 Director 20-16-7325 Maryland Usual Residence of Decedent or 28a-f shown notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 Yes 2 X No Loveville Maryland St. Mary's 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 40459 Parsons Mill Road 20656 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. Completed 3 X Widowed 4 Divorced Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mean once. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Arthur Ho1t Mary Norema James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 46, Loveville, MD 20656 Susan M. Mason/God-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/06/2010 Helen, MD Queen of Peace 21. Signal For line of Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal Signal 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Wide Spread Metostose Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner cuenna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe Yes 2 certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: injurv 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one re and title of certifier 29b. Signe 29c. License number 29d. Date signed (Month, Day, Year) 12-03-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mechanics ville Maylon & 20659 KeAchE MO O. Box 186

Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State of Walyand State Registra Amend#7.PerVRPGC12-7-10cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DANCY arcy Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Peince acovores SOUTHEALD HARYLAND HOSPITAL CLINTON **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Hours (Month, Day, Country) 571-72-4208 D.C. - 54 Yrs Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges HEIGHTS MD CAPITOL 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2074 Funeral Delle 5205 HILMAR USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event; the Me econday (0-12) College (1-4 or 5+) MOTOR OPERATOR Vechicle 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) PNC WILLIAMS MARGARET 19a. Informant's Name/Relationship (Type, Print). 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) White HILL HAR DRWL CAPITAL HEIGHTS, HD Francee 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 11-30-2010 Brentwood, 40 any injury once, Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Pacility WASH. DC 20011 BIANCHI 814 Upshur St NW 23a. Part 1. Enter the disease, or complication in that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L. retai do...
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year be detached Unknown 9 Unknown Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔼 Probably 4 ☐ Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate } 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1X Natural 5 Pending after death. Director: Aft 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: In the basis of exam, ation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Control ying furnic Fractioner: To the basis of exam, ation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and rearries as stated. (Check within 2 29b. Signa 29c. License number m 23...) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Milliam 170 7:08 AM November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death University of Maryland Medical Center maryland 13almove, If Under 24 Hrs. 8, Date of Birth Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) 1952 Maryland **Funeral** 1 ፟፟M 2 □ F Days 218-58-0768 (Month, Day, Year) February 26, Director 58 Yrs. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral l Hickory Lane Apt. 306 26682 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married 1 Tyes 2 No Specify: White Specify. 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 is of Health and Mental Hygiene.
If item 27 is marked other than "r prother traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Captain Mail & Freight Vessel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Franklin Dize Barbara Ruth Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lance Dize (Son) 26684 Passerdyke Court - Eden, Maryland 21822 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specity) Sunnyridge Memorial Park Nov. 27, 2010 | Crisfield, Maryland Funeral Say Coloresee 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisf<u>ield, Maryland 21817</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 90. Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 🗌 No ☐ Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes Other: 1 Anpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier e c want 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) greene

Registrar DHMH 17 Rev 7/2009

State

orie Grant

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital

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Baltimow, mD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 19, 4:34 AM M 2010 Nov. Sandra Wynelle Dashiell /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14548 Jackson Boulevard Eden Somerset If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖪 Director 267-70-9720 65 July 14, 1945 Florida Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 ☐ No Director Maryland Somerset Eden 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? US 14548 Jackson Boulevard 21822 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Hall Leggett Almyrtis Palmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Bruce Dashiell/ Husband 14548 Jackson Blvd., Eden, Md. 21822 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) St. Peters Cemetery 11/24/2010 Oriole, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home PA MO0295 11673 Somerset Ave, Princess Anne, Md. 21853 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALZHEIMER Physician 2 YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy nerforme 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 Residence 6 □Other (Specify) 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Box 68760, P.O. I Division or Vital Records,

ours after death.

neral Director: /
filled in by the f To the Hospital o within 24 hours aft To the Funeral Di

State Registrar

(Check only one)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier tale.

29c. License number 29d. Date signed (Month, Day, Year) D0029168

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1346 S. DIV. ST.

31. Date filed (Month, Day, Year) 32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. $\Omega \cap \Omega$ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Month 18/2010 ANGELA D. DOWNING :15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4244 SUITLAND ROAD SUITLAND PRINCE GEORGE"S 9. Birthplace (State or Foreign Country) Henderson, NC 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Months Hours 12/18/1959 Director 50 578-80-7780 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4244 Suitland Road 20746 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Secretary</u> Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Gaither Fisher Annie Rainey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Downing / Daughter 4244 Suitland Road Suitland, Maryland 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Premoval from State 4 Donation 5 Other (Specify 11/27/2010 | Waldorf, Maryland Heritage Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of FacilityPope Funeral Homes P.A. 401085 5538 Marlboro Pike Forestville, Maryland 20747 23a. Par 1. Inter the disease, or or plications mat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and I for use as the burial-transit Exami The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death ned by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be Records, 17 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 😾 No ☐ Yes 2x No 1 Tes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other 4 Nursing Home 5 🔀 Residence 6 Dother (Specify) 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 2 Natural 5 Pending 124 hours after death. Funeral Director: Aft leted filled in by the fur 2 Accident 3 Suicide 4 Homicide 1 🗌 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 16 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the To the To the To the T 29b. Signature and title of 29d. Date signed Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

31. Date filed (Month, Day, Year)

Box 68760

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		Registrar . Decedent's Name (First, Middle	e, Last)		061	incate of b	Cutii	2. Date of I	Reg. N Death	10%—	, 10	3. Time of I	Death
Physician Medica		Jean Dufort						Novem	oer 1	ay 18.	2010	8:55	<b>A</b> M
Examine		a. Facility Name (if not institution	, give street and n	umber)		4b. City, Town, or	Location of	Death			nty of Death		
-		123 Pasture Si				Rockvill			1	<b>font</b>	gomery	<u> </u>	
Funeral Director		. Social Security Number 106-30-5350	6. Sex 1 <b>X</b> M 2 □ F	7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B. Min. 09/19/		3	9. Birthp Count <b>Haiti</b>	lace (State or ry)	Foreign
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he Maryland or 28a-f sho notified at		laryland   Montgo	DWO 777		ckville						1	1 X Yes	
or 28		laryland   Montgo Oe. Street and Number	Juery	NO	CKATITE	10f. Zip Code			10g. C	Citizen o	of What Coun	try?	
leath with the litems 23a cer must be	ela	123 Pasture Sie	de Place	Unit B		20850			Unit	ted	States		
death item ner m	1	1. Marital Status	12. Was De Armed I	cedent Ever in Forces?	U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origir n, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)		14. R	ace - America lack, White, e	an Indian,	
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	5	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, G			☐ Yes 2 🗷 No		, -,			iack, white, e		
21215-003 rithin 72 hours at liene. r than "natural" the Medical Exc		15. Deceder	nt's Education		16a. Deced	lent's Usual Occupa	ation		16h		Business Ind		
215 in 72 in 72 in 72 in 72 in Med	<u> </u>	(Specify only higher Elementary/Seconday (0-12)		(1-4 or 5+)	(Give I	kind of work done d O NOT use retired)	uring most o	f working	100.	rana or	Dasiness inc	ooa y	
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altimore, Maryland 21215-0036  Air. Page 1 and 2 should be filed within 72 hours after partment of Health and Mental Hygiene.  portant: If item 27 is marked other than "natural", or promant: If item 27 is marked other than "natural", or promain or other traumatic event, the Medical Exam ce.	o	7. Father's Name (First, Middle, L	•					s Name (First, Midd	•	n Surnai	me)		
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or Health of Health of Health or Health or Titem 27 ir other tra	2	0a. Method of Disposition		201	b. Place of Dispo	sition (Name of		Date			n - City or To		
altimo mit. Page partment o portant: If y injury or Ce.		1 ☐ Burial 2 ☎ Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal fro Specify)	m State	**	natory or other place	/	/29/2010	Be-	ltsv	rille.N	larv1ar	ho
Baltimol pendit. Page 1 Department of Important: If i any injury or once.	2	1. Signa ur of Funeral Service	icensee	1,11000				McGuire					
	1	Juleril.	1. We	wer				nue,N.W.		ing	ton,D.	C. 200	12
		23a. Part 1. Enter the disease, or shock, or heart failure. List o	domplications that only one cause on	t caused the d each line.	eath. Do not ente	r the mode of dying	, such as ca	ardiac or respiratory	arrest,			Approximate Interval Betw	/een
∼ Physician/ Medical	- 1	Immediate Cause (Final disease or condition resulting in death)				nuclear P	alsy					Onset and De	eath
Examiner			Due to	o (or as a cons	equence ot):								
<u>.</u>	5	Sequentially list conditions, fany, leading to immediate	b. Due to	o (or as a cons	sequence of):								
kecuted and l-transit		Cause (Disease or iinjury that initiated events	с										
e exec	֓֞֞֜֞֜֞֜֜֞֜֞֜֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֜֜֜֓֓֓֓֓֜֜֝֡֓֓֜֜֡֓֓֡֜֜֝֜֜֡֡֡֡֜֝	resulting in death) Last	Due to	o (or as a cons	equence of):								
certificate be executed reding physician and use as the burial-transit configuration.			d		-								
ords, P.O. box 68/ requires that the death certific been signed by the attending I should be detached for use as	IF 2	FEMALE: 3b. Was decedent pregnant		utcome of <u>pr</u> e					Ĭ	234 L	Date of delive	n/	
F.O. BOX 68: s that the death certific gned by the attending be detached for use as hy Physician/M	2 2	in the past 12 months?  1  Yes 2  No	4 □ Pre	egnant at time		Ectopic pregnancy Other (specify)	<i>y</i>					*	ear
the d the by the tached	<u> </u>	9 🗌 Unknown	9 ∐ Un										
gned be dei	2 P	art II. Other significant condition	ons contributing to	death but not	resulting in the u	nderlying cause give	en in Part I.					cause of dea	
rds aquire equire een si nould nould	2  -							1	JYes 2			ably 4□U	
Hecords, The law requires tate has been sig page 2 should b	-							24a. Wa	s an opsy formed?	24b	<ul> <li>Were autop prior to con death?</li> </ul>	sy findings av npletion of ca	vailable use of
in The ficate in page		5. Was case referred to medical						1 □ Ye	s 2 <b>X</b> 1	Vo	1 Yes	2 🗆 No	_
VITAI hysician: nis certifii I director.	5 /	examiner?  1 \( \sum \) Yes 2 \( \bar{\bar{\bar{\bar{\bar{\bar{\bar{	Hospital:	Innationt 2	☐ ER/Outpatien	Othe	r·	(Check only one)					
OT / g Phy gerthis neral c		7. Manner of Death	28a. Dat	te of injury	28b. Time of	28c. Injury	at	ing Home 5 🗷 Re 28d. Describe					
on endin eath. or: Aft he fur		1 Natural 5 Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pendin Pend	gation	onur, Day, Tear)	) injury	M 1 □ v	? Yes 2□N	lo					
DIVISION OF VITAI RECORDS, tall or Attending Physician: The law requires re after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be a forest of the funeral director. To Re Completed		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Plac	ce of Injury - At ding, etc. (Spe	t home, farm, stre	et, factory, office		28f. Location City or To	(Street a		ber or Rural i	Route Numbe	er,
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  Ve the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.  Medical Certificate: To Re Completed by Physical Certificate.		9a. Certifier 1 X Certifying	Physician: To the	heet of my lo-	owledge deeth -	coured at the time	data and all	ace, and due to the	DUIC = (-)	and ===	nor co at-t		
he Hospita in 24 hours he Funeral ipleted filled	<u> </u>	(Check 2 Medical E	xaminer: On the b	asis of examina	ation and/or invest	igation, in my opinior	<ol> <li>death occu</li> </ol>	ace, and due to the ourred at the time, date and place, and due to	and plac	e, and d	lue to the caus	se(s) and man	ner stated.
within comp		9b. Signature and title of certifier		3.0 3000	.,	29c. License		p. acco, and due to			ed (Month, D		
5		> forta	lman	· M.	λ,	D20367			Nov	embe	er 19,2	2010	
	3	0. Name and address of person v	who completed ca	use of death (It	tem 23a) (Type, P	rint)							
	- 1	To 61 101 man 12	06 D:		_		_	1 00050					
State		Joel Kalman 13  1. Date-Fried (Month, Day, Year)	96 Picca	rd Driv Registrar's Sig	en oh we	ville. Ma	rylan	<u>a 20850</u>					

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

	For State Registrar	/F	(		Ce	rtifica	te of L	Death	<u></u>	Reg. N	.20	10	3898
n/	1. Decedent's Name Bohdan Jo	,							2. Date of D Month November	D	ay <b>201</b> 0	Year	
er	, ,		, give street and num	nber)		4b. City	y, Town, or	Location of Death				of Death	
	6410 Winne						etheso				Montgor	nery	
	5. Social Security N 068-24-03 Usual Residence of	50	6. Sex 1	7. Age (In yrs.		Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, E March 4	irth Day, Year) , 1923	3		
ctor	10a. State	10b. County		10c. Ci	ty, Town or Lo								
Dire	10e. Street and Nun	Montgo	mery			hesda	ip Code			T 40= 0	W		
Funeral Director		nnepeg R	oad				0817					nat Gou	nuy?
	11. Marital Status		12. Was Dece Armed Fo	edent Ever in U.	S. 13.			spanic Origin? (Sp n, Mexican, Puerto			14. Race		
ted by	1 Never Marr			2	.6	1 🗆 Yes	2 <b>X</b> No	Specify:			Specify:		
Completed		cify only highe	nt's Education est grade completed)		(Give	edent's Usu kind of wo	ork done c	ation luring most of wor	king	16b. i	Kind of Bus	siness In	dustry
	Elementary/Seco	onday (U-12)	College (1		I _	hysici					US	Armv	-Federal G
o Be	17. Father's Name (		.ast)			_		18. Mother's Nar	me (First, Middle	e, Maiden			
ဍ	John Dobi							Fugenia	Unknown				
	19a. Informant's Na  John G. Do												Code)
		☐ Cremation	3 - Removal from	State	Place of Disp cemetery, cre	matory or	other plac	NOV	Date <b>27</b> ,	Ι.		-	
	21. Signature of Fu		• • • • • • • • • • • • • • • • • • • •	\				J 10.	Uneral Home Inc. W., Silver Spring, MD 20901				
	22a Port 1 Enter t	ha disassa ar	complications that s	soused be deal							ng, MD	2090	
	23a. Part 1. Inter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Coronary Artery Disease Due to (or as a consequence of):												Interval Between Onset and Death
		1741		or as a conseq ension	uence of):								15 yrs
ine	Sequentially list co if any, leading to im cause. Enter Under	mediate lying	40		a consequence of): Cenal. Disease							- 0	
I Examiner	Cause (Disease or that initiated events resulting in death) I	3 '	C	or as a conseq									18 yrs
edical			d										
Physician/Medi	IF FEMALE: ,23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		Birth 2 🗌 Feta nant at time of	al death 3	☐ Ectopic ☐ Other (s		у					ery Day Year
۵	Part II. Other signif	icant conditio ialysis	ons contributing to de (hemodialys	eath but not res	sulting in the	underlying	cause giv	en in Part I.	- 1				
eted	Cancer of	: RI adday	with Cyste	ot omz					-				
Completed		Didoce	with cyste	County					per	opsy formed?	pri de	ior to co eath?	mpletion of cause
Be	25. Was case referre	ed to medical					26. Pla	ace of Death (Chec		2			
ု ရ	1 🗆 Yes 2 🗽			Inpatient 2				4 L Nursing H	ome 5X Res	idence (	6 🗋 Other	(Specify	)
Certificate:	27. Manner of Death  1 Natural 2 Accident	5 ☐ Pendin Investig 6 ☐ Could	gation	of injury h, Day, Year)	28b. Time o injury	of 2	28c. Injury work 1 □		28d. Describe	how inju	ry occurred	1	
	3 Suicide 4 Homicide	ome, farm, sti	reet, factor	ry, office		28f. Location City or To		Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say   Say					
ledical	(Check 2	Medical E	xaminer: On the bas	n and/or inves	stigation, in	my opinio	n, death occurred a	at the time, date	and place	4c. County of Death   Montgomery     1923   9. Birthplace (State or Foreign Country)   NY     10d. Inside City Limits   1   Yes 2   No     10g. Citizen of What Country?     USA   14. Race - American Indian, Black, White, etc.     Specify: White   16b. Kind of Business Industry     US Amiv-Federal Govt-Maiden Surname     10d. Inside City Limits   1   Yes 2   No     10d. Insidex			
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month										Month,	Day, Year)		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
	30. Name and addre		who completed caus	e of death (Item	1 23a) (Type,	Print)	_						

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For		State of						-		•	0.0	007
		1 - For Amende Registrar			, RG FO	CHD 12/ Cer	3/10 tificate	of Deati	h			2010	38	987
Physicia Medic		1. Decedent's Name (Fir	irst, Middle, Las Orise	^{st)} Blanche	. Duqu	iette				2. Date of Dea Month Novemb		25,2010		of Death
Examir		4a. Facility Name (if not i	institution, give	street and numb y Villag	per)			own, or Location			4c	. County of Death	n	
Funeral		Care 5. Social Security Number	and Re	habilita Sex 7	tion . Age (In yrs. I	last birthday)	If Under 1		Vill der 24 Hrs.	8. Date of Birt	h	Montgome 9. Birth	ery hplace (State	or Foreign
Director		039-20-8405 Usual Residence of Dece		□ M 2 ■ F	103	Yrs.	Months	Days Hour	Min,	April Day	22°,1	.907 Rho	để Isl	
yland -f shov ed at	ctor	10a. State 10b	b. County		10c. Cit	ty, Town or Loc	ation						10d. Inside (	City Limits
ne Mar or 28a	Funeral Director	Maryland M	Montgom	ery			Montg	gomery	Villa	.ge	40.00			es 2 No
with the 23a country be	eral	19301 Watk		11 Road			101. ZIP C	2088	16	ľ	10g, Ci	tizen of What Cou		
death items ner m	Fun	11. Marital Status	ALIIO III	12. Was Decede	ent Ever in U.S		Vas Deceder		Origin? (Sp	ecify Yes or No-		14. Race - Ameri	ican Indian,	
s after ral", or Examir	d by	1 Never Married : 3 Widowed 4		1 Yes 2 If Yes, Give Year or Date	2 No			No Spec		rrican, etc.)		Black, White,	, etc. White	
2 hour "natu edical	Completed	15. (Specify o	5. Decedent's E only highest gra			16a. Deced		Occupation done during m	ast of work	rina I	16b. K	ind of Business Ir		
vithin 7 iene. r than the Me	Com	Elementary/Seconda		College (1-4	or 5+)	life. DC	NOT use re	etired) emaker		9		Own Ho	Ome	
filed wal Hyg	a B	17. Father's Name (First,	, Middle, Last)			J	HOME		other's Nam	ne (First, Middle,	Maiden :		JIIC	
uld be Menta narked latic e	우		rt Dion						Anna	Gelina	s Di	on		
2 shouth and 1th and 27 is not reaum.		19a. Informant's Name/F	, , ,			1						Town, State, Zip		
1 and of Hea item		Donald A.  20a. Method of Disposition	ion			Place of Dispos	sition (Name	of		Date	20c. Lc	MD 208		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cr 4 Donation 5	Other (Specif	fy)	tate c		ter & Cemete	ery	Nov:		Cove	entry,Rho		land
permi Depar Impor any in		21. Signature of Fune/a	Service Licens	Paulas/1	k CFS	P M	Name and A oleswo 6401 R	Address of Eac Orth-Wi Ridge R	lliam load.	s, P.A. Damascu	, Fu	neral Ho Maryland	ome 20872	
e		23a. Part 1. Enter he dis shock, or h ≠ rt failu	lure. List only o	plications hat cau	used the death								Approxima Interval Be	ate
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	_	F FEMALE: 23b. Was decedent pregr in the past 12 month 1 ☐ Yes 2 █ No	ths?		rth 2 🗀 Feta ınt at time of d	al death 3	Ectopic pre				1	23d. Date of deliv Month		Year
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quires then signed and be o	<u> </u>											■ No 3 □ Pro		
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iysicia is cert directe	To B	examiner?  1 Yes 2 No	-	Hospital:	patient 2 🗆	ER/Outpatient		Other:			ence 6	Other (Specify	v)	
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Attendi death ctor: A y the fi	Certificate:	2 Accident 3 Suicide 6	Investigation Could not be	e <del></del>	Injury - At hou	me, farm, stree	М	1 Yes 2		005			10. 11.	
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Within Com		29b. Signature and title of		0 15				cense number				e signed (Month,		
	-	20.11	Vine	Fant			D4	1102MD			No	vember 2	29,201	0
4	l s	30. Name and address of		inu Gant				or's Dr	ive.	Germant	own -	MD 208	74	
State	~	1. Date filed (Month, Day	ÿ, Year)	32. Regi	Prais Signatu						,			
Registra		NI C	OV 292	ZUTU 📝	Call Billard .	A A	De Kal							

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		For State Registrar		Sta	ate of M	arylan		artment o rtificate o		alth and N ath	/lental Hy	gien Reg. N	2010	38988
Physicia	n/	1. Decedent's Name		e, Last)							2. Date of De Month	ath	^{ay} 2010 Year	3. Time of Death
Medic	al	ERMA B.  4a. Facility Name (if		nive street a	and number)			4h City Toy	un orlo	ocation of Death	11	-	c. County of Dear	0245 M
Examin	er	_10004 TIN		_				UPPER					PRINCE C	
Funeral		5. Social Security N		6. Sex	7. Ag	e (In yrs. la	ast birthday)	If Under 1	Year I	f Under 24 Hrs. Hours Min.	8. Date of Bir	th	g, Bir	thplace (State or Foreign
Director	8	577-48-7 Usual Residence of		1 □ M 2	X   F	92	Yrs.	Months	,ayo   1	IVIIII.	3/30/1	918	Wasi	nington, DC
and show lat	or	10a. State	10b. County			10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
Maryla 28a-f	Director	Maryland	Prince	e Georg	ge's	Up	per M	ar1boro	)					1XXYes 2 ☐ No
th the	al D	10e. Street and Nur		1 0				10f. Zip Co				-	itizen of What Co	ountry?
ath wii	Funeral	10004 T:	ımberwo		as Decedent	Ever in 11.5	3 13		772	anic Origin? (Sp	ecify Yes or No-		SA 14. Race - Ame	origan Indian
ter des or ite	by F	1 Never Marr	ied 2 🗆 Mar	ried 1	med Forces? Yes 2 🛣			If Yes, specify	Cuban, I	Mexican, Puerto	Rican, etc.)		Black, Whit	
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uld be I Ment narke natic e	₽ P	Arthur '								Blanche		_		
2 shorth and the and traun		19a. Informant's Na			<b>1</b>			,					nr Town, State, Zi	
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Page nent o ant: If ıry or		1 🖾 Burial 2 4 🗌 Donation	☐ Cremation 5 ☐ Other (\$	3 □ Remov Spec <b>if</b> y)	al from State		emetery, cre	matory or other 7e t	r place)	11/2	9/2010	Was	shington	, DC
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The protectart if time ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service I	//			2	2. Name and A	ddress				Homes, P	
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,		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition CONGESTIVE HEART FAILURE											Approximate Interval Between Onset and Death	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	edical												and manner as sta	
the H thin 24 the F mplet	Me	only one) 5 - Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marrier as st.									stated.			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G911 1/26/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 THURMAN BAY ELLIS 30 11:05PM Nov. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death W. Jarrettsville Road Jarrettsville Harford Social Security Nun 473 7. Age (In yrs. last birthday) If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-18-147 Months Days Hours Min. 3 /4 / 192 Country) unknown Director 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location the Medical Examiner must be notified at Director MD. 1 Yes 2 No Harford Jarrettsville 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 1585 W. Jarrettsville Road 21084 United States items 2 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces
1 X Yes 2 Black, White, etc. 1 Never Married 2 Married ö δ 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Widowed 4 Divorced White Completed WW II Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) United States and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Engineer Government event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ൧ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 (Wife) 1585 W. Wilhelmina H. Ellis Jarrettsville Rd. Jarrettsville, MD Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🖟 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. cemetery, crematory or other place) 4 Donation 5 Other (Specify) arroll 2010 Cremation Hampstead, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each like. Approximate Interval Between Onset and Death 2 y cars Immediate Cause (Final Pnysician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the utgaerlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ artery disease, hypertension, 2 No 3 Probably 4 Unknown Completed aortic stenosis, type Were autopsy findings available prior to completion of cause of 24a. Was an Jas performed No page death? certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes **2√** No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5  $\square$  Pending Natural injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation after death

Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) the Hospital within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0054573 12/1 axl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 3718 Jarrettsville, MD. 21084 E. Crai Morrasville Rd. Mary 31. Date filed (Month, Day, NEC 1 0 2010 32. gistr Son State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 26, Physician/ 2010 2:30 AM Juanita Lee Edger Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert 3860 Harrison Lane Huntingtown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Texas Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Funeral 1 M 2 X F 0976671952 58 215-62-9364 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ---- any injury or other traumatic event any injury or other traumatic event. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 X No Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3860 20639 U.S.A. Harrison Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Yes, Give 1 ☐ Yes 2 💢 No Specify: Specify: 3 Divorced 4 Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) clerk retail grocery 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Edison Estill Edith Norma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey L. Edger, husband 3860 Harrison Lane, Huntingtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 12/02/2010 4 Donation 5 Other (Specify) Alexandria, VA . Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Illian 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Palmonary faulure Physician/ disease or condition Medical resulting in death) Examiner Chronic obstructive end severe Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death signed by the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Mansplant Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has performed? Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 PResidence 6 Other (Specify, 2 12 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D42935 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registra s Signature

NOV 29 2010

Catherine Brophy, M.D., 10845 Town Center Blvd., Suite 203, Dunkirk, MD 20754

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Stacey lovember 24 2010 Edwards /Medical 4b City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner hester River Hospital nestertowy MId If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day. Birthplace (State or Foreign
Country) **Funeral** Year) 1 X M 2 □ F Months Hours Yrs. MARYLAND **Director** 215-62-2274 12/02/1965 44 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1XIYes 2∏No MD KENT ROCK HALL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5776 S. HAWTHORNE AVENUE 21661 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🕅 No ģ 3 Widowed 4 Divorced "natural" Completed of Health and Mental Hygiene. Item 27 Is marked other than "natur r other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 PLANT FOREMAN CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Leo Edwards Janet Marie Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLYN EDWARDS- Wife 5776 S. Hawthorne Avenue Rock Hall, Maryland 21661 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WESLEY CHAPEL 11/30/2010 ROCK HALL, MARYLAND 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM 130 SPEER ROAD CHESTERTOWN, 1 Approximate Interval Between Onset and Death part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** oronam /Medical Due to (or es a consequención): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Ö this certificate has been signed by the ral director, page 2 should be detached 9 Unknown ď. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes 1 Inpatient 2 RER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospital or within 24 hours after death.

To the Funeral Director: After a consideral filled in by the fur 1 Satural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed use of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 3 U 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 & 18 per Fh g911 1/4/11 TT
Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5 & 18 per Fh g911 1/4/11 TT For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MARY CORDELIA JORY EWING Medical Novembe OIQ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Easto tsellot (Enons) 220-52-9047 800-07-3878 If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 F Months Days Hours Min. (Month, Day, **Director** 90 Yrs. MARYLAND NOV 1920 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 🐒 No MARYLAND QUEEN ANNE'S CHESTER 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21619 UNITED STATES 1123 PARSONS ISLAND ROAD 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21275-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify 3X Widowed 4 ☐ Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) Dals Name (First, Middle, Maiden Surname) မ <del>DAISÉY</del> EVANS JOSEPH JORY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1123 PARSONS ISLAND ROAD, CHESTER, MARYLAND, 21619 HOLLY BAKER/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State NOV. Date 1 👿 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND STEVENSVILLE CEMETERY 2010 21. Signature of Funeral Service Licenses Name and Address of Facility LLOWS, HELFENBEIN & NEWNAM FUNERAL 5 SHAMROCK ROAD, CHESTER, MARYLAND 23a. Part 1. Enter the disease, or complications that coded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fibrilla-'entrice lar disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Secritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D0053110 November 18 126 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 11-19-10 DENNIS DESHIELDS M.D. 219 S. WASHINGTON ST.. EASTON, MARYLAND 21601 2010 32. Degistrar's Signatud

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 38993 State RegistramFND#106:10f.19bperINF.11/29@ntificate.of.Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ Thelma C. Ehrenreich November 21 8:59 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Montgomery **Examiner** Olney Montgomery General Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 New Jersey 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗆 M 2 🏞 F Hours Months Director 144-10-1494 May 21, Usual Residence of Decedent 10c. City, Town or LocationOlney 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10d. Inside City Limits Director Rockville-Montgomery Maryland 1 🗆 Yes 2 🏝 No 10f. Zip Code 20832 10e. Street and Number 16917 MacDuff Avenue 10g. Citizen of What Country? TISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ₩ Widowed 4 □ Divorced Specify. White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Education Be 18. Mother's Name (First, Middle, Maiden Surname) Anna Simon 17. Father's Name (First, Middle, Last) George Cockley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health a item 27 i 16917 MacDuff Avenue, Rockville, Richard F. Ehrenreich / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or o
once. 1 Burial 2 Cremation 3 Removal from State November 27, 2010 Olney, Maryland Norbeck Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. 23a, Part 1. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician, Kesnia tom Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ō Month Year Pregnant at time of death the 9 Unknown Division of Vital Records, P.O. signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign Arrhy thous 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Inpatient 2 ER/Outpatient 3 IDOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 0050410 11/23/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olnez 20832 31. Date filed (Month, Day, Year) State

Registrar

**NOV 24** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 24 2:31 ам 2010 Eloise Shenton Eberspacher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Queen Annes The Heartland House Grasonville 8. Date of Birth
July 3, 1933 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F 220-26-8929 Marvland Director 77 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director MD Dorchester Vienna 1 Yes 2 K No 10f. Zip Code 10g, Citizen of What Country? Funeral 4121 Middletown Branch Road 21869 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: white Specify: "natural", 3 X Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) farmer agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Henry Shenton Lida Schuvler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Frase 5304 Newton Road, Preston, MD daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/29/10 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park Cambridge, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events for as a consequence of Examine and burial-tran Due to (or as a consequence of) resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 A Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) the funeral 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, in by t determined filled Medical 🔯 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar 29b. Signature and title of

31. Date filed (Mo

30. Name and address of person

Registrar's Signatu

29c. License number

29d. Date signed (Month. Day, Year)

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 19a, b per inf., g912,03/2011dhb Mental Hygiene
trar Certificate of Death Reg. No. 1 - For A Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5 NoVMedical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, of Location of Death Examiner 4c George 8. Date of Birth (Month, Day, If Under 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 1 M 2 □ F Months Days Hours Min. Country) Director Marylan or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at death with the Maryland Director 1 Ves 2 No TEOrge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural" Completed 3 Widowed 4 □ Divorced Black Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical! 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) oPulmonary Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print)
Andre C. Chester ot and Number or Rural Route Dr. Trappe, MD State, Zip Code) sharon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 101/10 4 Donation 5 Other (Specify) Ca 21. Signature of Funeral Service Licensee 22. Name and Address of acility Henry Funeral Home, 510 washington St. Washington 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Pulmonary Disease Immediate Cause (Final disease or condition Chronic Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events and Due to for as a consequence of as the burial attending physician for use as the burial Physician/Medical law equires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Division of Vital Records, P.O. een signed b Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End Stage Renal disease Malignant hypertension 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No ge 2 should Congestive heart failure Dlabetes wellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 Tes 2 No completed filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 🔀 Natural 5 Pending Accident
Suicide Investigation 24 hours after death Funeral Director, 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29c. License number 0 29d. Date signed (Month, Day, Year) MD D61007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

NOV 3 0 **2010** 

31. Date filed (Month, Day, Year)

Kenneth Khandagle

12520 Prosperity

# 320

Dir

Silver Spring, Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - State Amend 19b per FD, DOR, Certificate of Death

Reg. No. 2 0 | 0

1. Decedent's Name (First, Middle, Last)

Physician

1. Decedent's Name (First, Middle, Last)

Frank, Hayno, Era

Physician /Medical Examiner

Funeral Director

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

þ

Completed

Be

P

ion

Certificat

Medical

31. Date filed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural" or items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in items 23a or 28a-f show Important in i

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Day 24, 20/0 2220 PM Frank Wayne Era November 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death DORCHESTER DORCHESTER GENERAL CAMBRIDGE HOSPITAL 8. Date of Birth (Month, Day, Year)
Nov. 22,1940 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1XM 2□ F 217-36-2259 70 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6316 Snug Harbor Road 21631 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐Yes 2 XNo Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Arthur Era Ruth Louise Hurst 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6316 Sung Harbor Road, East New Market, MD 21631 Doris L. Era/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State East New Market Cem. 4 Donation 5 Dother (Specify) 11/29/2010 East New Market, MD 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 21. Signature of Funeral Service Live see Approximate Interval Between Onset and Death Parri. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final St= Swall Cell disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11.25.10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar CAMBRIDGE

MD 21613

THANWY

NOA 88

503

32. Redistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2ÖÎO Betty Mae Elzey 4:20 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Chesapeake Woods Center Cambridge Dorchester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** (Month, Day ) ^{Year)}1932 1 🗆 M 2 🕱 F Months Hours 220-28-4526 78 Oct. Maryland Director Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Cambridge Dorchester 1 X Yes 2 No 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21613 Funeral 525 Glenburn Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. Specify: "natural" Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry leath and Mental Hygiene. n 27 is marked other than "n ar traumatic event" (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) electronics line worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bergie Mae Seward Thomas James Wheatley permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1047 Taylors Island Rd., Madison, MD 21648 p.r. Samuel M. Horseman 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State Crematory of Delmarva 11/27/10 Delmar, DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service 21613 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on the attending physician and thed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 Yes 1 Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 Wo Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Spin 24 hours after death. Funeral Director; A Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 - Homicide determined Medical 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) tle of certifier 29b. Signature an 29c. License number 29d. Date sig hed (Mghth, Day, Year) 4

DHMH 17 Rev 7/2009

State Registrar and address of person

L013

31. Date filed (Month, Day,

Bramble

who completed cause of death (Item 23a) (Type, Print)

D, O.

egistrar's Signatur

NABR

10-08934

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Tadrian M. Enna	als	State of Maryland / Department of Health and Mental Hygiene  - For State  Certificate of Death  Death  Death  Certificate of Death	Q
Physici	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death 3. Time of Death	
Medical Exami	iner	100 4 1 av 70 0 1 1 2 1 2 10 10 10 10 10 10 10 10 10 10 10 10 10	
¥.		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Dorchester General Hospital  Cambridge  Dorchester	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or For	reigi
Director		220-92-6537 1 MM 2 F 3/ Yrs. Months Days Hours Min. May 9, 1979 Mary/and	1
any		Usual Residence of Decedent	_
id how at	_	Tod. IIside City Elli	
farylar 28a-f s	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
h the h	١	807- Park Lane 2/6/3 USA	
eath with the Maryland items 23a or 28a-f she ust be notified at once	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black, 15. Was Decedent of Hispanic Origin? (Specify Yes or No- 16. Race - American Indian, Black, 17. Wester Married 18. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispanic Origin? (Specify Yes or No- 19. Was Decedent of Hispani	
fter de	y Fu	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify: 12 CK	
hours a	ed by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done  16b. Kind of Business/Industry	_
36 nin 72 nin 72 han ", dical I	plet	College (1-4 or 5+)	
5-00 ed with Hygiene other	Completed	17. Father's Name (First, Middle, Last)  Welder  Welding + tabr.'cation  18. Mother's Name (First, Middle, Maiden Sumame)	V
D 21215-0036 Should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f show natic event, the Medical Examiner must be notified at once.	Be	Dietrich Lamont Gaskins Bonnie Anitia Ennals	
bou hou is a stice	의	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  807- Park Lane Cambridge, Maryland 2/61.	2
re, MIs 1 and 2 s of Health at If item 27 ter traumi	1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	<u> </u>
Pages 1 nent of F tant: If i		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Crematory Greenlawn Cene 12/1/10 Cambridge, MD.	
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If iten 27		21. Signature of Funeral Service Licensee  Name and Address of Facility  He way F. A.	
Physician	-	23 Fart I. Enter the disease, or complications that caused the de-th. Do not enter the mode of dying, such as ordiac or respiratory arrest, shock, or hear Approximate Inter-	yal
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Narcotic and alcohol intoxication  Between Onset an Death	
Examiner		or condition resulting in death)  Due to (or as a consequence of):	_
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Due to (or as a consequence of):	
	Examiner	Co. Due to (or as a consequence of):	
auted nd ransit	Ĕ	events resulting in death) Last Due to (or as a consequence of):	
iO, e be executed ysician and burial - transit	edical	X UNPENDED AMENDED 27,28a-f, per ME g910 12/16/10 TT	_
		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery	
x 68 th cert	icia	past 12 months?    4   Pregnant at time of death   5   Other (Specify)	
Division of Vital Records, P.O. Box 6876 with Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	اھ	1 Yes 2 No 3 Probably 4 V Unknown	n
rds, requir	Completed	24a. Was an 24b. Were autopsy findings available	
Reco	E S	autopsy prior to completion of cause of death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No	•
tal R	Bec	25. Was case referred to medical examiner?	
f Vir Physic er this	라	examiner?  1 Very 1 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other  Nursing Home 5 Residence 6 Other:  28b. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred	
on o ending ath. or: Aft	tion	Natural 5 Pending Fd 11/21/10 Fd 3:00 pm 1 Yes 2 No unk	
Vision Atta	Certification:	Accident investigation	ty
Di ospital hours a uneral I		3 Suicide 6 Could not be determined Specify Found: residence Cambridge, MD  28e. Place of Injury - At home, farm, street, factory, office building, etc. of Town, State) O/Park Lane Cambridge, MD  28f. Location (Street and Number or, Rural Route Number, Cit of Town, State) O/Park Lane Cambridge, MD	_
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in t	10	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  One)  2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To with	Mec	29b. Standture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	_
		O.C.M.E. November 22, 2010	
	Ī	30. Name and address of person who completed cause of death (Item 23a)	
Sta	ate	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year) 32. Registrar's Signature.	
Regist	rar	31. Date filed (Month, Day, Year) NOV 3 2010 32. Registrar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 State Registrar  1. Decedent's Name (First, Middle, I		······································		ificate of		a Mental H	ygiene Reg. No.	010	38999
	Physic	cian/ dical	Herber	,	Funderb	urk			2. Date of D	Death	Voor	3. Time of Death
	Exam		4a. Facility Name (if not institution, g  St. Thomas More				4h City Town	or Location of D	Novemb	er 14,		8:20 A.
			Kenabilitation	<u>Center</u>				ttsville			nty of Death	eorges
	Funera Directo	_	5. Social Security Number 6 250–24–8448	Sex 7. A	Age (In yrs. last bir <b>87</b>	N	If Under 1 Year Months Days	If Under 24 I	Irs. 8. Date of B	irth	9. Births	place (State or Foreign
			Usual Residence of Decedent		07	Yrs.			March	9,1923	Sout	n Carolina
	yland -f sho ed at	핞	10a. State 10b. County		10c. City, Tow	n or Locat	ion				1	0d. Inside City Limits
	r 28a notifi	Director	District of Colu	mbia ————	Was	shing	ton				- 1	1 X Yes 2 □ No
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral	3828 Blaine Str	eet, N. E.			10f. Zip Code <b>2001</b> 9			10g. Citizen o		
	death item		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was			(Specify Yes or No.	United		
21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene.  27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Completed by	1 Never Married 2 X Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates.	May 194 Jan.1946		es, specify Cuba		(Specify Yes or No- erto Rican, etc.)	Special	ace - America ack, White, e $\mathbf{b}_{y}$ : $\mathbf{B1}a$	etc.
75	n 72 h	m per	15. Decedent's (Specify only highest of	Education Irade completed)	16a.	(Give kind	s Usual Occup	ation during most of w	rorkina	16b. Kind of	Business Ind	ustry
212	withir giene er tha		Elementary/Seconday (0-12)  12th grade	College (1-4 or	5+)	ine. DO N	OT use retired) nter		Cirtaing	W1.1	D	
	filed tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)				The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	18. Mother's N	ame (First, Middle,			Company
Z S	should be filed wand Mental Hygi ris marked other raumatic event, i	2		erburk				Etta			ne)	
Maryland	12 shorth and 27 is n		19a. Informant's Name/Relationship (		<b>(e)</b> 19b.	Mailing A	ddress (Street a	and Number or F	Rural Route Numbe	r, City or Town.	State. Zin Co	nde)
တ်	and Heal em		Janie Lee Wimes  20a. Method of Disposition	Funderburk	38	28 B	laine S	treet,N	.E.;Wash	ington,	D.C. 2	0019
nore,	rage 1 nent of ant: If it any or o		1 X Burial 2 Cremation 3	Removal from State	20b. Place of cemetery	Dispositio ⁄, <i>cr</i> e <i>m</i> ato	n (Name of ry or other place	e) Nov	23 2010			
	さきせき		4 Donation 5 Other (Spec		Quant			Cemete	ry	Quanti	co,Vir	ginia
7	Depar Impo any ir		Sandula	L 3.94	1	Tnc	• 600 V	s of Facility R	. N. Hori	on Comp	any M	orticians,
			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	plications that caused	the death. Do no	t enter the	mode of dying	. such as cardia	Correspiratory arr	W.;Wash		n,D.C.2001
	nysician/ Medical xaminer	er	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	1 DAG		Approximate Interval Between Onset and Death						
ted	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	a consequence of)							
лэөхө	ın and ial-tra		that initiated events resulting in death) Last	c. Due to (or as a	consequence of	:						
90 e pe	nysicia ne bur	lical	L	d.								
68760 ertificate be	ing ph easth	/Medical	FEMALE:									
Box death c	is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	hysician	3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	2 ☐ Fetal death time of death	5 U Oth	er (specify)			23d. Dat Moi	e of delivery oth Da	
<b>P.O.</b>	gned se de	o f	art J. Other significant conditions co	ntributing to death bu	t not resulting in t	he underly	ring cause giver	n in Part I.	23e. Did tob	acco use contri	bute to the c	cause of death?
rds equire	pinould	eted	Julminay 1	my nesto.	SCEPO							ly 4 TUnknown
ision of Vital Records, P.O. Attending Physician: The law requires that the	has b	를	Dementra						24a. Was ar	1 24b. W	/ere autopsy	findings available
Ä å	icate r, pag								autops perform	y ned? d	rior to compli eath?	etion of cause of
of Vital	certif	ш	5. Was case referred to medical examiner?  1  Yes 2 No	lospital:				e of Death (Chec		I NOI I	Yes 2	_ No
of \	er this	<u>ව</u>	7. Manner of Death	1 Inpatier 28a. Date of injury	nt 2 ER/Outpa		7	4 Nursing H	ome 5 Reside	nce 6 🗆 Other	(Specify)	
On	r: Afte	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year) Zob. Time injur		work?	·	28d. Describe how	v injury occurred	1	
r Attendin	recto		3 Suicide 6 Could not be determined	28e. Place of Injury	/ - At home, farm,			s 2 🗆 No	28f   anation (21)			
	illed in			building, etc.	(Specify)				28f. Location (Stre City or Town,	State)		te Number,
Hosp	To the Funers after deam.  completed filled in by the funeral		Pa. Certifier 1 Certifying Physical Check 2 Medical Examin	cian: To the best of m	y knowledge, deat	th occured	at the time, da	ate and place, ar	nd due to the cause	e(s) and manner	as stated.	
o the	ompl		(Check 2 Medical Examin only one) 3 Certifying Nurse b. Signature and title of certifier	Practioner: To the be	st of my knowledg	e, death o	ccurred at the tin	ne, date and place	t the time, date and ce, and due to the c	place, and due t ause(s) and man	o the cause(s	) and manner stated.
	17°		000	0.1			29c. License nu	mber	29	d. Date signed (	Month, Day,	Year)
	M	30	Name and address of person who co	mpleted cause of day	th (Item 202)	- Paris ii	001	852		Nememi	real 18	2010
	44	_ L'	Paul A. DeV	ORE MI)	4 233 (Type	OIL	ee, sh	34. P.	14 4	4 -1	11.	2,7
77	State Registrar	_	NOV 2 9 2010 Lens	32. Registrar's	Signature		_ ,US D(	sieg (Co)	11551	115:114	(LIV)	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:20pm - essenden Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg Wilson Health Care Center 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year Aug. 22 1 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Hours 213-38-4463 105 **Director** 1905 Usual Residence of Decedent shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Md. Montgomery Gaithersburg 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 301 Russell Avenue, 20876 United States #235 death v 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Government Stenographer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Flora Baird Thomas Wesley Chance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 soft Health a item 27 i 21525 Davis Mill Road, Germantown, Md. 20876-4419 Thomas A. Fessenden / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot Page 1 cemetery, crematory or other place)
Gate of Heaven Cem. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/2/10 Silver Spring, Md. 4 Donation 5 Other (Specify) 21. Signatule of Funeral Service Licensee 22 Name and Address of Facility
Muriel H. Barber Funeral Home 00 0. Box 5038. <u>Laytonsville</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ementiz disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) the g Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death Check only one) Be examiner? Other: 2 🖪 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ite: ffer nd Number or Rural Route Number,

Division of Vital Records, P.O. Box 68760

ath. r: A re fu	ij	2 Accident	Investigation		М	1 Yes 2	No No		
tal or Atters after de al Directo	l Certifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)		ory, office		eation (Street and Number or Rur or Town, State)	al Route No
ne Hospit in 24 hour he Funera pleted fill	Medical		Medical Examiner	: On the basis of examination	n and/or investigation,	in my opinion, death o	ccurred at the time	the cause(s) and manner as state, date and place, and due to the cue to the cause(s) and manner as	ause(s) and
To the within To the comp		29b. Signature and ti	tle of certifier	) ham	2	9c. License number	48	29d. Date signed (Month	
5				Deted cause of death (Item		Russell	Ave	Geithershurg	M
Stat Registra	e	31. Date filed (Month)	Day, Year) 10V 29 201	32 Jegistrar s Signa	A. par	V .			
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e, and due to the cause(s) and manner stated

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